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“wiʔaac”

wiʔaac. wiʔaac. wiʔaac. wiʔaac.
Hello Hello Hello Hello

ʔəsχid čəxʷ. ʔəsχid čəxʷ.
How are you? How are you?

ʔəsχubil čəd. ʔəsχubil čəd. ʔəsχubil čəd. ʔəsχubil čəd.
I am fine. I am fine. I am fine. I am fine.

[This is a welcome song by Zalmāi (ʔəswəli) Zahir (n.d.: 7)]

University of Alberta

*Towards A Better Understanding of Medical Systems and Practices:
The Coast Salish sbəltədaq Ceremony and Biomedicine*

by

Mark Ebert



A thesis submitted to the Faculty of Graduate Studies and Research in partial fulfillment of the requirements for the degree of *Master of Arts*

Department of *Anthropology*

Edmonton, Alberta

Fall 2001

University of Alberta

Faculty of Graduate Studies and Research

The undersigned certify that they have read, and recommend to the Faculty of Graduate Studies and Research for acceptance, a thesis entitled *Towards A Better Understanding of Medical Systems and Practices: The Coast Salish sbəltədaq Ceremony and Biomedicine* submitted by *Mark Ebert* in partial fulfillment of the requirements for the degree of *Master of Arts*.

For Dr. Bob, Andie and Hoke

ABSTRACT

In this thesis I discuss distinctions made in medical anthropology between biomedicine and ethnomedicines and between disease and illness. I argue that these distinctions hinder cross-cultural understandings of medical systems and practices. Such distinctions, I argue, are made in medical anthropology implicitly giving primacy to biomedical categories and explanations. I continue by addressing the shortcomings of a proposal in medical anthropology to overcome this primacy and propose that the dwelling perspective may provide a better avenue for cross-cultural understandings. By looking at medical systems and practices through the dwelling perspective I argue that they provide a reflection and reinforcement of a particular mode of engagement in the world. To illustrate how medical systems and practices reflect and reinforce this engagement, I discuss a Coast Salish shamanic healing ceremony in which a group of shamans journey to the land of the dead.

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LUSHOOTSEED PRONUNCIATION KEY

(Adapted from Bates *et al.*, 1994; Hilbert *et al.*, 2001)

ʔ	a glottal stop, like the pause in “uh-oh”
a	“a” as in “father”
b	same as in English
c̥	glottalized “ts”
č	“ch” as in “church”
č̥	glottalized “ch”
d	same as in English
ə	schwa, “u” as in “but”
gʷ	like the “gw” in “Gwen”
i	either “ee” in “beet” or “ai” in “bait”
kʷ	“qu” as in “queen”
l	same as in English
ɬ	like “thl” in “athlete”
p	same as in English
q	sounds like an English “k” but further back in mouth
q̥	glottalized “q”
qʷ	like “kʷ” but further back in mouth
q̥ʷ	glottalized “qʷ”
s	same as in English
š	“sh” as in “ship”
t	same as in English
t̥	glottalized “t”
u	either “oo” in “boot” or “oa” in “boat”
w	same as in English
w̥	glottalized “w”
xʷ	a bit like “wh” in “which” but more raspy
χ	“ch” like German “ich,” but deeper in throat
y	“y” as in “yell” or “yes”

CHAPTER ONE: Introduction

This thesis is about understanding groups on their own terms. I argue that if medical anthropologists want to understand medical systems and practices in cross-cultural contexts they must do so according to the group's own terms. My concern is with medical systems and practices from a cross-cultural perspective, and not with studies in medical anthropology that have other foci. This point is important as the field of medical anthropology includes many diverse perspectives, many of which avoid the problems I discuss.

I realize that the biomedicine-ethnomedicine and the disease-illness distinctions are not necessarily at the forefront of current medical anthropological thought. It is my contention that when cross-cultural medical anthropological research is being undertaken, these two distinctions are of great import. As many authors have pointed out, the biomedicine-ethnomedicine distinction is problematic. In my thesis I focus on one attempt by some medical anthropologists to overcome this distinction — the proposal by, for example, Robert Hahn (1995), Atwood Gaines (1991, 1992), Mark Nichter (1992) and Lorna Amarasingham Rhodes (1996), that biomedicine is just one ethnomedicine among many ethnomedicines. They argue that, like other ethnomedicines, biomedicine is rooted in cultural presuppositions and values. I do not contend the basic principle of this proposition, that biomedicine is one ethnomedicine among many, what I contend is the reasoning for this proposal.

Central to my critique of this proposal is the distinction made in medical anthropology of disease and illness. This distinction is based on the opposition of nature,

or biology, and culture. In the literature “disease” typically refers to biological structure or functioning, while “illness” refers to the individual or subjective experience. I use “ill-health” in this text to refer to the basic phenomenon that both the labels “illness” and “disease” refer to in medical anthropological literature since Arthur Kleinman (1980; *cf.* Fabrega, 1972; Hahn, 1984; Young, 1982).

The theoretical basis for my critique is taken from Tim Ingold’s ecological perspective which he has called the “dwelling perspective” (e.g., 1995, 1997c, 1998a, 2000a). Ingold makes an important distinction between what he calls “MTK” and “LTK.” MTK refers to “[traditional] knowledge as constituted within the language and idioms of modernity,” and he argues that traditional knowledge so formulated is constructed in opposition to scientific knowledge (Ingold and Kurttila, 2000). “Traditional knowledge,” formulated as MTK is basically the imposition of the Western or scientific conception of knowledge onto other knowledge systems. LTK is defined by Ingold as referring to “traditional knowledge as generated and sustained within the practices of locality” (1997c). LTK arises from the individual dwelling in the world, MTK represents the antithesis of dwelling, in that “traditional knowledge,” represented as such, displaces the knower by portraying knowledge based on the model of a disengaged, objective way of knowing. In this scientific model of knowledge, “traditional knowledge” as MTK is located in culture. Science supposedly has access to the acultural, objective nature, while traditional knowledge (as MTK) is a cultural interpretation of this nature. An important dichotomy in the formulation of MTK is that between nature and culture. In my thesis I also use MTK to refer to the Western or scientific conception of knowledge.

The association of traditional knowledge as MTK with culture and scientific knowledge with nature has an important implication, in that scientific knowledge represents a posited universal, or etic, knowledge, while traditional knowledge within MTK represents a more specific, emic, form of knowledge. There are direct parallels in some of the medical anthropological literature as exemplified by the aforementioned disease-illness distinction. Since disease represents the biological manifestations of ill-health, the biomedical disease nosology is supposedly universal in application. “Illness” refers to the cultural expression of disease. Thus illness, so formulated, is an emic category while “disease” is represented as an etic category.

This view of humans, in which nature and culture are split, portrays the human being as “animal plus” (Ingold, 1990a, 1991a, 1993b, 1996b, 1997b). Humans are seen as animal, in the sense of their biological body, but are different from animals due to something added on, the “plus” of culture. This view of human beings is distinctly Western, and Deborah Gordon (1988b) proposes the division of nature and culture is a “tenacious assumption in biomedicine” which persists in biomedical practice. If the separation of nature and culture is a “tenacious assumption” in biomedicine, and this is the same separation that divides disease and illness, can this separation of nature and culture also be a tenacious assumption held in medical anthropology?

Comparing¹ and evaluating medical systems and practices cross-culturally has involved the use of one medical system (biomedicine) as the baseline, and then measuring how another system compares. Often in medical anthropology biomedical categories are used (Browner, 1999), in the assumption that a universal biology underlies

ill-health. I argue though that the use of biomedical categories hinders a researcher's ability to understand another medical system or practices, and actually prevents cross-cultural understanding of two, or more, non-biomedical medical systems.

Is the argument that I am putting forward in my thesis an extreme form of relativism? Possibly. A paradox is inherent in the literature. Some authors propose that biomedical ill-health categories are universal and others propose that they are grounded in culture. Who is correct? My argument is that it is neither, in that the problem exists in the approach. If biomedical researchers do not have access to the universal, "really real" biological nature of human beings then the distinction of disease from illness made in medical anthropology and the use of biomedical categories, or disease, as an etic system in cross-cultural research then is arbitrary. This is why the distinction of disease from illness implicitly gives primacy to biomedical nosology and knowledge in the cross-cultural medical anthropological literature. But the proposal that "biomedicine is one ethnomedicine among many" based on its cultural rootedness does not deny that there is a "really real" biological nature. This proposal fails to deny the existence of a "really real" biological nature, in that it is based on a cognitive view of the world, where in the senses provide raw data to the mind, which interprets the data through the lens of culture. This view of the world allows an individual to discuss culturally different versions of reality. Hence illness, as conceived, can then represent a cultural expression of the underlying universal "really real" disease. I suggest this is the "animal plus" portrayal of human beings, in which disease affects the biological or animal part that all human beings have in common, while the plus part, culture, is represented as illness.

¹ In this thesis is that I have tried to avoid using the word "comparison" (as in cross-cultural comparison). Instead I use the word "understand" as I am attempting avoid the connotation of an evaluative concern in

Biomedicine, Ethnomedicine and Medical Anthropology

Although Arthur Rubel and Michael Hass suggest that “Healing, shamanism, and the relationship between illness and supernatural forces have captured the interests of ethnologists and the public from anthropology’s earliest days” (1996: 113). Erwin Ackerknecht, for example, is part of the heritage in medical anthropology “for whom terms like “primitive,” “magical,” “mystical,” “pre-logical,” “proto-scientific,” and “folk” [were] all common adjectives for “medical beliefs” among “natives” ” (Good, 1994: 29). Ackerknecht used these terms because, he lacked a better term “we call “primitive medicine” the medicine of the so-called “savage” or “uncivilized” people” (1942: 503). I am by no means trying to suggest that medical anthropologists should use Ackerknecht’s language. For, as Ackerknecht continues, “We wish by no means to indicate by this expression [primitive medicine] that this medicine gives us a simple picture of the first stages of medicine” (1942: 503). I agree with Ackerknecht when he warns that “conclusions have to be drawn with extreme caution,” and that one should not use biomedical explanations and standards in studying other medical systems:

But our medicine is not *the medicine* nor our religion *the religion*, and there is not one medicine but numerous and quite different medicines in the different parts of the world.... This method of seeking in primitive medicine only for what it has in common with ours and of projecting into primitive medicine our categories leads to somewhat strange results. [Ackerknecht, 1942: 503]

Ackerknecht later writes, “We are naturally inclined to think of primitive medicine in terms of rationality, just as primitives usually interpret our medicine in terms of magic. It

is not difficult to see that both procedures are projections” (1945: 29). Part of the purpose of this thesis is to recontext Ackerknecht’s point into contemporary medical anthropological discourse.

Charles Hughes coined the term “ethnomedicine” in 1968 (Hughes, 1968; Rubel and Hass, 1996: 116). The coining of the term “ethnomedicine,” was part of the formalization of a mode of inquiry has had particular implications in cross-cultural research in medical anthropology. Hughes contrasted non-biomedical systems to what he called “modern” medicine (1968: 88). The term “ethnomedicine” was used to replace what Byron Good calls the “embarrassing evolutionary language” that the earliest writings on culture and medicine shared with the larger discipline of anthropology (1994: 29). By 1972, Horacio Fabrega, Jr. was able to note that there were two emphases emerging in the field of medical anthropology: ethnomedical and biomedical. Fabrega characterized ethnomedical studies as approaching medical problems from the perspective of the groups and individuals studied, while biomedical studies, “view medical problems using the categories of Western scientific medicine” (Fabrega, 1972: 167-168). I contend that the coining of the term “ethnomedicine” signified the separation of biomedicine from all other ethnomedicines and implied that biomedical explanations were the standards or norms in which all other systems were compared to. Biomedical rationale has been persistent in much of the medical anthropological literature.

The biocultural, or medical ecological, approach in medical anthropology provides a contemporary example of biomedical explanations in medical anthropological literature (*e.g.*, Alland, 1977, 1990; Armelagos *et al.*, 1992; Brown *et al.*, 1996; McElroy and Townsend, 1996; Wiley, 1992). This approach “views health and disease as

reflections of relationships within a population, between neighboring populations, and among the life forms and physical components of a habitat. [It] considers health to be a measure of how well a group of people has adapted to the environment” (McElroy and Townsend, 1996: 2). The biocultural approach is based on biomedical explanations: “Western biomedicine provides us with a specific biological and physiological description of disease and illness” (Armelagos *et al.*, 1992: 39); or, “Biomedicine has cross-cultural, universal applicability when it accurately reflects natural and biological reality” (McElroy and Townsend, 1996: 67). In other words, the biocultural approach tends to focus primarily on diseases as biological processes that are considered in the model as universal. In this system, illness is conceived of as the cultural expression of disease.

Using a different perspective, Arthur Kleinman proposed separating the notion of disease from illness. He defined “illness” as referring to the “socially learned and culturally shared ways of perceiving, labeling, experiencing, and reacting to symptoms,” while disease represents the recasting of illness in terms of the biomedical perspective (Kleinman, 1986: 230-231; see also Fabrega, 1972; Good, 1994; Hahn, 1984, 1995; Kleinman, 1980, 1988; Rhodes, 1996; Young, 1982). A related distinction is that between curing and healing. In Kleinman’s thinking, this latter distinction means that diseases are cured and illnesses healed (1980; see also Waldram, 2000).

Another major approach in medical anthropology, critical medical anthropology (CMA) (*e.g.*, Baer, 1993, 1996, 1997; Baer *et al.*, 1986; Lock and Scheper-Hughes, 1996; Morsy, 1996; Scheper-Hughes and Lock, 1998; Singer, 1986, 1993; Singer *et al.*, 1986). While CMA focuses on macrolevel political and economic issues, this approach has been

criticized for implicitly giving primacy to biomedical explanations: “Critical views implicitly reaffirm the theory of universal diseases and [bio]medicine’s perception, labeling, and classification thereof. They differ with [bio]medicine only in their attribution of the causes of putatively empirical diseases” (Gaines, 1992: 18-19; see also Gaines, 1991; Good, 1994; Morgan, 1987).

Thus we see a set of distinctions that can be expressed as: curing:healing :: disease:illness :: biomedicine:ethnomedicine, and, as I will argue later in this thesis, :: knowledge:belief.

My Argument

I argue that the distinctions discussed above are a hinderance to the understanding of medical systems and practices. In addition to the distinctions discussed there is a tendency to privilege biomedical categories and explanations in cross-cultural research. The supposed universality of its biomedical categories and explanations is a projection of Western biological categories and explanations onto other medical systems. James Waldram warns that “it is erroneous to assume that biomedicine only “cures disease” or that traditional medicine² only “heals illness,” or that they are completely distinct phenomena” (2000: 604-605). I use the term “ill-health” to refer to both illness and disease, because many authors (*e.g.*, Gordon, 1988b; Hahn, 1984; Nichter, 1992; Rhodes, 1996; Waldram, 2000) have pointed out that the usage of “disease” and “illness” is problematic.

² Waldram states that the “definition of *traditional* medicine remains problematic,” but that “[s]uch medical systems are often described under the banner of “ethnomedicine” ” (2000: 603).

Most recently medical anthropologists have argued that biomedicine is not a single entity. Annemarie Mol and Marc Berg suggest that the image of a unified biomedicine dissolved “when anthropologists started to undertake empirical studies of health care within North American and Europe” (1998: 4). They point out that instead of a single biomedical belief system or culture, anthropologists found “a conglomerate of highly divergent practices” (Mol and Berg, 1998: 4-5). In another context, Mary-Jo DelVecchio Good attempts to explain the phenomenon Mol and Berg encounter suggesting that there are global-local interactions:

These local worlds of biomedicine, however, are ‘transnational’ in character. They are not cultural isolates, biomedical versions of indigenous healing traditions. Rather local meanings and social arrangements are overlaid by global standards and technologies in nearly all aspects of local biomedicine. [1995: 462]

But Good’s proposal is explicitly concerned with biomedicine, and thus, does not aid in understanding *all* medical systems and practices, and not just the various forms of biomedicine. I discuss two problems that grounding biomedicine in culture runs into: first, is which culture is biomedicine grounded in; and secondly, if biomedicine is its own culture, how then can internal diversity that Mol and Berg discuss be explained? As I will discuss below, if we situate medical systems and practices in a dynamic engagement in the world (the “dwelling perspective”) and view them as processes of LTK, one can gain a better understanding of any medical system or practice.

The distinction of disease from illness represents an academic division of labour, according to Lorna Amarasingham Rhodes who suggests that this distinction is based on a segregation of biomedical and medical anthropological ways of knowing (1996: 171). Rhodes argues that a majority of the research in medical anthropology “is based on a

bracketing of biomedical expertise as referring to areas of knowledge not within the purview of the anthropologist” (1996: 171). As Kleinman has suggested, “The illness/disease distinction provides medical social scientists with ... an autonomous subject matter that has been virtually unstudied in medicine — the nature of illness experiences and problems” (Kleinman, 1986: 231). Thus the medical anthropologist is seen to properly study culture while the biomedical researcher studies biology.

In this thesis I also critique the proposal that biomedicine should be considered one ethnomedicine among many. This proposal is based on the notion that “like all ethnomedicines, [biomedicine] is rooted in cultural presuppositions and values” (Hahn, 1995: 132) and draws upon Clifford Geertz’s notion of “cultural systems” (1973, 1983). Many medical anthropologists have realized that the split in theoretical representation of biomedicine as separate from ethnomedicine is inherently problematic, and have attempted to overcome the dichotomy (*e.g.*, Armelagos *et al.*, 1992; Fabrega, 1990; Good, 1995; Gaines, 1991, 1992; Hahn, 1995; Hahn and Kleinman, 1983; Nichter, 1992; Rhodes, 1996). I will show that this proposal does not overcome the biomedicine-ethnomedicine dichotomy. In failing to overcome the dichotomy, this proposal implicitly privileges of biomedicine over ethnomedicines.

The theoretical basis for my critique of the ethnomedicine-biomedicine and disease-illness distinctions and of the “biomedicine as an ethnomedicine” proposal is largely drawn from the work of Tim Ingold (*e.g.*, 1990a, 1992, 1993a, 1993b, 1996a) and Bruno Latour (1993). Beginning with a discussion of the location of science as a basis of contemporary and historical biomedicine (*e.g.*, Good and Good, 1993; Gordon, 1988a, 1988b; Romanucci-Ross and Moerman, 1997) I discuss how notions of “rationality”

(Good, 1994; Kirmayer, 1988; Shweder, 1986; Tambiah, 1990) and “belief” (Good, 1994), with respect to science, have affected research in medical anthropology (*e.g.*, Browner, 1999). In the context of this thesis, the questioning of the location of biomedicine in positivistic science has had a major impact on medical anthropology in the development of a tradition of cross-cultural analysis, especially centred on debate over relativism (Browner *et al.*, 1988; Comaroff, 1983; Descola, 1996; Geertz, 1984; Good, 1994; Ingold, 1993a; Latour, 1993; Shweder, 1986; Spiro, 1986; Tambiah, 1990). Some authors suggest (*e.g.*, D’Andrade, 1976; Spiro, 1986) that adopting scientific methodology is necessary for anthropology to continue as a science, and, as with biocultural medical anthropologists discussed above, biomedical/scientific explanations provide very real data on universal phenomena. Geertz, on the other hand, has argued that science is being used to argue against relativism:

It is not, or anyway not here, the validity of the sciences, real or would-be, that is at issue. What concerns me, and should concern us all, are the axes that, with an increasing determination bordering on the evangelical, are being busily ground with their assistance.
[1984: 268]

Like Geertz, I am not concerned over issues of the validity of the sciences or biomedicine. What I am concerned with in this thesis is the imposition of scientific or biomedical categories onto other medical systems and practices. As Good has argued, “grounding cross-cultural analysis on practices current in contemporary biomedicine may produce findings more artifact than real,” and that “holding up our own biological language of illness and care as the norm seems profoundly inadequate” (1994: 23). Thus, Rubel and Hass suggest that a central task in medical anthropology is to find a neutral language in which all medical systems and practices are treated equally thereby allowing

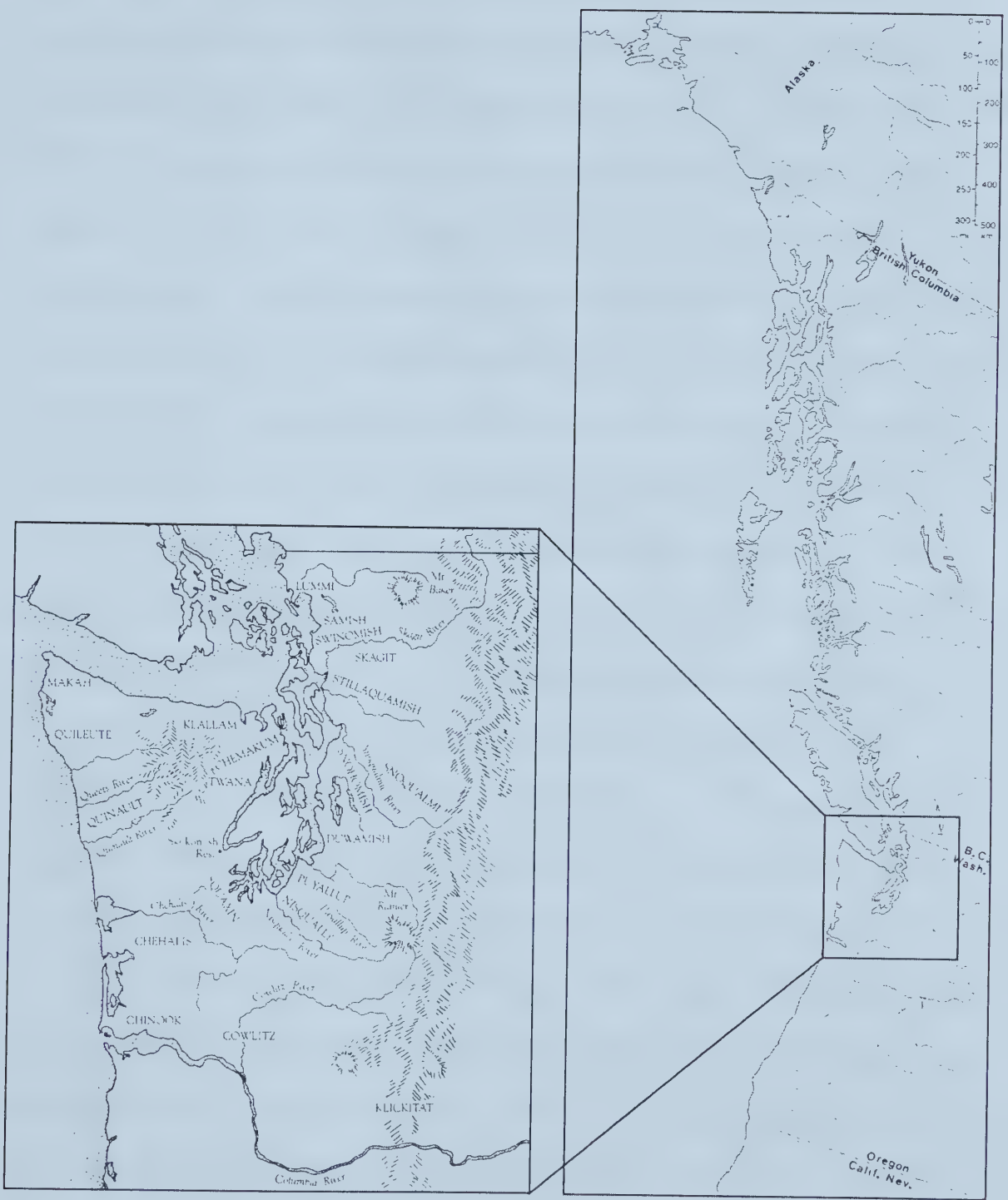
us to compare and contrast medical systems without making *a priori* judgments (1996: 116-117).

What insights can medical anthropologists take from Ingold's ecological anthropology approach? Although Ingold is mainly concerned with the dichotomy between Traditional Ecological Knowledge (TEK) and science, many of the core concerns of ecological anthropology are similar to those of medical anthropology. For example, the dichotomies between TEK and science, biomedicine and ethnomedicine, and between disease and illness are all based on the Western dichotomy of nature and culture. Science and biomedicine both study "nature" while anthropology, whether ecologically or medically focused, studies "culture." Authors in medical anthropology, such as the "biomedicine as an ethnomedicine" proponents, have contended though that studies in biomedicine are grounded in and influenced by culture (*e.g.*, Comaroff, 1982; Fabrega, 1990; Gaines, 1991, 1992; Good, 1994; Good, 1995; Hahn, 1995; Haraway, 1991; Kirmayer, 1988; Nichter, 1992; Rhodes, 1996; Romanucci-Ross and Moerman, 1997; Singer, 1993; Taussig, 1980). I argue though, following Ingold (*per. comm.*, 2000), that by suggesting that biomedicine is grounded in culture does not deny that there is a "really real" nature or biological reality. This implicit acceptance of a "really real" nature in some medical anthropological writing creates a hierarchy of natures/realities based on increasing subjectivity. By asserting that science and biomedicine are grounded in the cultural, in some medical anthropological literature, there is an implicit assertion that by breaking out of the shackles of culture, science and biomedicine would truly have access to the "really real" nature or biological reality. The "biomedicine as ethnomedicine" proponents may contend this statement, arguing that they are only asserting the cultural

biases in science and biomedicine. But science and biomedicine, through their methodology, are supposed to be acultural and objective. Thus the assertion of cultural biases in science and biomedicine suggests a methodological shortcoming (the “shackles” of culture) that if researchers could overcome, they would then have access to the “really real” nature or biological reality. As Gordon (1988a) discusses in her essay on clinical science, there is a realization that there is some “art” to the “science” of clinical practice, but there is a movement in the clinic to remove this “art.” I propose we resituate medical systems and practices in the dynamic engagement with the world, what Ingold calls “LTK”³ (e.g., Ingold, 1997c, 2000a; Ingold and Kurttila, 2000). We might then overcome hierarchical relationships between biomedicine and ethnomedicine, disease and illness, culture and nature, and the overlapping nature of these hierarchies that posit objectivity. Moreover, by considering medical systems and practices as reflecting, reinforcing and being based on a particular mode of engaging the world, the internal diversities in medical systems are more easily explained.

To illustrate my discussion of how medical systems and practices reflect and reinforce a particular mode of engagement with the world (LTK) I will explicate the *sbəłtədaq* healing ceremony, a former practice of the Coast Salish people in the Puget Sound region of Washington State (see map 1). This ceremony involved a group of shamans journeying to the land of the dead to recover a lost or stolen spiritual aspect of a patient. Although this ceremony has not been performed in over one hundred years (see Haeberlin, 1918; Miller, 1992) it still has implications today. As Jay Miller writes, “I am

³ “LTK” is not an acronym. Rather it stands for (traditional) knowledge as constituted in the practices of locality.



Map 1: Map of Pacific Northwest Coast with inset of the Puget Sound region of Washington State and the Native groups that resided there (adapted from Suttles, 1990; inset from Eells, 1985).

all too aware that although this ceremonial has gone, Lushootseeds⁴ continue to suffer from soul loss, to consult shamans, priests, and ministers, and to need the solace of healing rituals to return errant spiritual features of their individual existences” (Miller, 1999b: 1). Furthermore, Wolfgang Jilek and Louise Jilek-Aall (1982) suggest that the *sbəltədaq* ceremony provides the prototype for more contemporary Coast Salish shamanic practices. As well, the ceremony provides a fundamental system of symbols for other Coast Salish modes of healing (Jilek and Jilek-Aall, 1982), many of which are still practiced today (pers. comm., Palmer, 2001). Some of the ritual paraphernalia currently used are based on the items formerly employed in the *sbəltədaq* ceremony (Jilek and Jilek-Aall, 1982: 129). For example, the carved cedar *sgʷədilič* boards, which are still in use today in the Smokehouse religion (pers. comm., Palmer, 2001), are, according to Miller, very similar in form and function to the painted boards of the *sbəltədaq* ceremony.⁵ This ceremony has ongoing importance to the Coast Salish of the Puget Sound region.⁶ It “epitomizes and validates the main features of Lushootseed culture” (Miller, 1992: 8). This healing ceremony demonstrates the dwelling perspective, insofar as it reflects and reinforces a particular mode of engagement with in the world (LTK).

The organization of the following discussion of the issues is as follows: In chapter 2, I critique the “biomedicine as an ethnomedicine” proposal using the dwelling perspective. Then in chapter 3, I discuss the *sbəltədaq* ceremony to illustrate how a medical practice can reflect and reinforce a particular mode of engagement with the world. Finally, in chapter 4, I delve further into my analysis of how the separation of

⁴ Lushootseed is the language spoken by those Coast Salish people residing, traditionally, on the southwestern through to the eastern area of the Puget Sound (see Hess, 1995; Hess and Hilbert, 1975).

⁵ For a discussion of *sgʷədilič* boards, their uses and the associated beliefs see Collins (1949) and Hilbert (1980).

biomedicine from other medical systems privileges biomedical explanations and knowledge. I conclude that the dwelling perspective provides a better and more dynamic means for understanding all medical systems and practices.

⁶ Hereinafter the label “Coast Salish” in this thesis will refer to the peoples in the Puget Sound region who practiced the ceremony unless specified.

CHAPTER TWO: Understanding Medical Systems and Practices

In her 1997 address at the Society for Medical Anthropology's meetings, Carole Browner discusses her concern for what she calls the "medicalization of medical anthropology" (1999: 135). "By this," Browner states, "I mean the trend among us to study entities as they are conceptualised by biomedicine — cancer, tuberculosis, or arthritis, for instance, or "stress," "PMS," or "postpartum depression" " (1999: 135). This medicalization of medical anthropology, suggests Browner, is not necessarily a negative movement, but one negative consequence of this movement is that "many more medical anthropological studies ... uncritically accept biomedical illness categories and explanations" (1999: 135-136). A major change in medical anthropology has been a narrowing of research scope to focus on biomedically-defined conditions (Browner, 1999: 137). Research now focuses "on pragmatic issues of improving the health and health care situations of contemporary people, both "Western" or "non-Western" " (Pelto and Pelto, 1996: 293). But this focus by medical anthropologists on the improvement of health and health care is done, as suggested by Browner above, by accepting biomedical nomenclature and nosology.

Of interest to this discussion is Carole Browner *et al.*'s (1988) earlier criticism of the prominence of meaning, symbolic and epistemological studies by many medical anthropologists. In 1988, these authors suggested that this focus by medical anthropologists has hindered the field's development: "Yet it has been medical anthropology's strict emphasis on problems of meaning and on health and illness beliefs, practices, premises, and values that has inhibited development of the field" (Browner *et*

al., 1988: 682). They counter that “the critical issue for comparative ethnomedical research is how to “maximize equivalence,” that is, how to ask the same question in different settings and how to establish criteria by which equivalence can be asserted” (Browner *et al.*, 1988: 682). But the comparative framework proposed by Browner *et al.* has limited applicability in multiple areas of medical anthropological concerns. Of importance in the context of this thesis is that Browner *et al.* admit that their framework cannot “shed light on the nature of “folk” illnesses that have no physiological manifestations” (Browner *et al.*, 1988: 682). Browner *et al.* suggest that the reason why they restrict their framework to physiological processes is “because physiologically these processes are essentially the same specieswide, with culture impinging minimally as a confounding variable” (1988: 682). This focus on physiological processes reinforces, what Tim Ingold has called the “animal plus” view of humans (which will be discussed in a subsequent section) in which humans are portrayed as basically animal with the added feature of culture (see Ingold, 1990a). Deborah Gordon’s critique of biomedicine contains a concern similar to Ingold’s:

Similarly “natural man” is distinct from “cultural man,” the “animal of man” is distinguishable from the “human” This animal/natural part is considered universal, the human part ... is where diversity shows up. ... [A] common notion is that humans are animals with rationality and culture added. [Gordon, 1988b: 27]

Browner *et al.*’s criticism that there is a reluctance on the part of medical anthropologists to explore the interface between biology and culture is reified by their framework in which culture is “a confounding variable” (1988: 682). The separation of physiology from culture by Browner *et al.* reflects two key distinctions in medical anthropology: the ethnomedicine-biomedicine and the disease-illness distinctions. I argue that these two

distinctions are related, in that the latter reinforces the former. Any attempt at cross-cultural research that does not address these two distinctions asserts a biological, and thus biomedical, primacy, which constrains any attempt to understand non-biomedical systems and practices. In this chapter I will focus on one attempt in medical anthropology to overcome the biomedicine-ethnomedicine distinction (*cf.* Hahn, 1995). I will demonstrate that Robert Hahn does not succeed in overcoming the dichotomy, and also how his particular proposal reinforces the dominance of biomedicine. Finally, I will discuss an alternative approach that will facilitate the analysis of medical systems and practices on more equal terms.

Subjectivity, Objectivity and the Comparison of Medical Systems

Similar to the disease-illness distinction made in medical anthropology, the distinction between “signs” and “symptoms” in biomedicine reflects the viewpoint of an objective nature in science: “medicine distinguishes between “signs,” objective indications in the patient’s body, and “symptoms,” the patient’s complaints” (Gordon, 1988b: 25). The patient’s experience of ill-health is aligned with subjectivity. Diagnosis in biomedicine becomes “the interpretation of the patient’s symptoms by relating them to their functional and structural sources in the body and to underlying disease entities” (Good, 1994: 8). In other words, “Disordered experience, communicated in the *language of culture*, is interpreted in light of disordered physiology and yields medical diagnoses” (Good, 1994: 8). We see here an evident connection between subjectivity and culture. Moreover, the attribution of objectivity to the biomedical practitioner and subjectivity to

the patient creates “two different ways of knowing — subjective awareness and direct observation” (Kirmayer, 1988: 59).

This notion of an objective biomedicine (and science) versus the subjective person is what Richard Shweder calls one of the “standard dichotomies.” These dichotomies are “a parallel series of oppositions beginning with the opposition between the objective versus the subjective and ending with the opposition between the natural sciences versus the humanities” (Shweder, 1986: 177). I argue the disease-illness dichotomy can be inserted into Shweder’s series, and, as the result of this latter dichotomy, there is an academic division of labour where “Anthropologists “decode” culture, just as physicians “decode” symptoms” (Gordon, 1988b: 27-28). The criticism of the Traditional Ecological Knowledge (TEK)¹-science dichotomy provides a similar argument to mine.

Insights from ecological anthropology are of value. As Robert Hahn and Arthur Kleinman suggest, medical systems are a “product of a dialectic between culture and nature” (1983: 306). Although nature, as discussed above, has a dual role in biomedicine, the connection of nature and culture in ethnomedical systems is supposedly fundamental (Voeks and Sercombe, 2000: 679). In ecological anthropology TEK can be considered synonymous with the conception of illness in medical anthropology: “It appears that TEK is conceived of as something specific to place, if not also to particular people [*sic.*], and it is differentiated presumably in both form and content from other types of knowledge generally and from science specifically” (Usher, 2000: 184). Although TEK applies more to a group’s body of knowledge, Peter Usher argues that TEK is “derived from ...

experience and traditions” (2000: 185), much like illness (Good, 1994: 116; Hahn, 1995: 28; Kleinman, 1988: 3). Furthermore, TEK is often placed in contrast to science (*e.g.*, Bielawski, 1996: 216), again, much like illness is to disease. The TEK-science dichotomy has created a similar division of labour as the disease-illness dichotomy has for medical anthropology with the result being that anthropology has simultaneously reinforced the dichotomies and “does not undermine but actually reinforces the claim of natural science to deliver an authoritative account of how nature really works” (Ingold, 1998a: 162).

Furthermore, Tim Ingold argues,

This neat division of labour has the effect of replicating not only the dichotomy between nature and culture, but also that between reason and tradition, the very fulcrum upon which the West has always based its claim to the superiority and universality of academic knowledge. For the anthropologist is, in effect, ‘up there’ with the scientist: where the latter purports to be able to study nature directly, free from the distorting lens of received tradition, the former can likewise claim to recognise worldview as worldviews, alternative constructions of an independently given reality. [2000: 3]

In medical anthropology a similar process has gone on. If we go back to Hughes’s definition of ethnomedicine, at the beginning of this chapter, we see an explicit association of belief with ethnomedicine. Also there is a further association of belief and culture with ill-health, which leads us back to illness. Thus illness — through culture, subjectivity and belief — is juxtaposed with disease — through nature, objectivity and science — and dichotomizes two ways of knowing ill-health as suggested above.

Furthermore, these “two different ways of knowing” figure prominently in the development of biomedicine: “The patient’s subjective account of distress was deemed

¹ One problem with TEK is the inconsistent definition of it, as sometimes it is referred to as “TEK,” “traditional knowledge,” “aboriginal knowledge,” “local knowledge,” or “indigenous knowledge” (Usher, 2000: 184; Agrawal, 1995). But note that it is always in opposition to scientific knowledge.

unreliable and essentially irrelevant to the physical diagnosis. Thus, the conscious awareness of the patient was *subordinated* to the physician's privileged knowledge" (Kirmayer, 1988: 59; emphasis added). Laurence Kirmayer suggests that this is the real dualism — "between the physician as active knower and the patient as passive known" — and this real duality "is captured in the distinction between disease and illness" (1988: 59). What we have, then, is a knowledge hierarchy in which the objective biomedical knowledge is elevated above subjective cultural knowledge. This knowledge hierarchy in biomedicine has serious ramifications in the cross-cultural study of medical systems. As Hahn suggests, the act of interpretation in cross-cultural analyses is influenced by "the interpreter's assumptions about the rationality and motivations of the local population and about the way the world works" (1995: 109). "Such assumptions," continues Hahn, "derive from the observer's own cultural tradition" (1995: 109). Good, using the example of "leechcraft," suggests that it is problematic to use "categories from today's rapidly changing medical knowledge as a basis for judging the empirical validity of claims of other" (1994: 22). With the privileging of biomedical knowledge through this knowledge hierarchy, the cross-cultural comparison of medical systems and practices is hindered in two areas: rationality of the "other" and relativism.

The first ramification involves the notion of false beliefs or irrationality. The creation of a hierarchy of knowledge, through the devaluation of patient's subjective knowledge, creates a notion of "rational behaviour." Scientific rationality "is reluctant, even opposed, to admitting other modes of consciousness or other world orientations into any space it already occupies" (Tambiah, 1990: 151). This scientific rationality is important with regards to both ethnomedicines and patients. With regards to the patient,

this rationalism combined with the paternalistic attitude of the biomedical practitioner, “in which the physician, better than the patient may be thought to know and judge what is best for the patient” (Hahn, 1995: 143), means that when a patient fails to comply with the biomedical practitioner they are labelled as irrational (Good, 1994; O’Neill, 1986; Young, 1981). In other words, since the biomedical practitioner’s knowledge is “better,” because of its objective and scientific bases, it would be “irrational” for a patient not to follow the practitioner’s instructions. Furthermore, since biomedical knowledge is “better” than subjective knowledge it is believed that biomedical knowledge can be used to “evaluate the relative benefit of treatment, and thus have a more thorough measure of efficacy in response to illness” (Armelagos *et al.*, 1992: 42; *cf.* Waldram, 2000).

The second ramification follows from this use of biomedical standards to evaluate other medical systems, and hinges on relativism. This ramification involves notions such as “indigenous science” (*e.g.*, Bielawski, 1996). Bruno Latour suggests that such notions are wrapped up in the “modern constitution,” which “defines human and nonhumans, their properties and their relations, their abilities and groupings” (1993: 15). The “modern constitution” creates two “Great Divides.” The first divide is between human and nonhuman and is accomplished through science and the laws of nature. The second is between Us and Them and is based on the first divide: “In order to understand the Great Divide between Us and Them, we have to go back to that other Great Divide between humans and nonhumans.... In effect, *the first is the exportation of the second*” (Latour, 1993: 97). The second divide pits Westerners (moderns) versus everyone else, the difference being that the “moderns” not only

differ from others as the Sioux differ from the Algonquins, ... but that they differ radically, absolutely, to the extent that Westerners

can be lined up on one side and all the cultures on the other, since the latter all have in common the fact that they are precisely cultures among others. In Westerners' eyes the West, and the West alone, is not a culture, not merely a culture. [Latour, 1993: 97]

This divide has implications for cultural relativism, for in order to be able to avoid placing cultures on a continuum of progression, in a manner much like that of the 19th Century unilineal evolutionists (*e.g.*, Morgan, 1877), some anthropologists, with regard to science, “think they can do this only by bringing them [the “primitives”] as close as possible to the sciences” (Latour, 1993: 97). Philippe Descola argues that this form of relativism “presupposes the existence of what needs to be established” (1996: 84). Geertz states that anthropologists are reluctant “to draw ... the conclusion that science, ideology, art, religion, or philosophy, or at least the impulses they serve, are not the common property of all mankind,” and that as a result there

has grown a whole tradition of argument designed to prove that “simpler” peoples do so have a sense for the divine, a dispassionate interest in knowledge, a feel for legal form, or a for-itself-alone appreciation of beauty, *even if these things are not immured in the neat, compartmentalized realms of culture so familiar to us*. [1983: 74]

As Latour states of this type of relativism, “give the primitives a microscope, they will think exactly as we do” (1993: 98).

So how can we compare medical systems and practices? How does one balance relativism and universalism? As Geertz states, “The fear of relativism, ... has led to a position in which cultural diversity ... amounts to a series of expressions ... of a settled, underlying reality, the essential nature of man” (1984: 272). To which Melford Spiro counters, “if cultures are incommensurable and if the characteristics of human nature and the human mind are predominantly culturally determined, how is it at all possible for an

ethnographer to understand a group that is different from his or her own?" (1986: 268).

Within medical anthropology, Arthur Rubel and Michael Hass suggest, "The effort to contrast and oppose "other" kinds of medicine with the increasingly dominant [biomedicine] ... represents a serious problem, long impeding comparative medical studies" (1996: 116). Browner *et al.*, although acknowledging the limitations of what they call bioscience,² still suggest, "there are compelling reasons for using bioscience as the etic system for cross-cultural studies" (1988: 682). The main reason they give is that "[w]ith bioscience, knowledge is accumulated through a set of standardized, precise, and replicable methods and procedures" (Browner *et al.*, 1988: 682-683). George Armelagos *et al.* also suggests, and for similar reasons, that biomedicine provides the best system for comparison: "Western biomedicine provides us with a specific biological and physiological description of disease and illness. Due to the relative ubiquity of the biomedical method, it can serve as a common point of comparison in many health studies" (1992: 39).

Both Browner *et al.* (1988) and Armelagos *et al.* (1992) acknowledge that the biomedical nosology is limited in the sense that biomedicine "does not have the concepts required to understand many of the causes, effects, and consequences of illness reported by other ethnomedical systems," (Browner *et al.*, 1988: 683) but both sets of authors imply that this is due to cultural influences — reflecting the "animal plus" perspective of humans alluded to earlier. But is physiological debility a necessary criteria for disease?

Although physiological debility is necessary for "disease," as defined in medical anthropology (*e.g.*, Kleinman, 1988: 5-6), Hahn suggests that we should give primacy to

² Browner *et al.* "use the term "bioscience" to refer to the empirical study of the human body using the standardized concepts, measures, and techniques that are generally accepted in biology and medicine in

the patient's experience of ill-health (illness) because "while the patient's theory may be partly or largely mistaken, it is his/her experience of suffering which engenders the whole medical enterprise. The sufferer's judgment, rather than that of biomedicine defines the *underlying problem*" (1984: 17). This can be seen in the example of congenital hip dislocation among the Navajo (see McDermott *et al.*, 1969). This dislocation of the hip is considered a disease in biomedicine. But among the Navajo it is the opposite and is not even considered a "particularly important disability" (McDermott *et al.*, 1969: 129). I do not deny that if I experience ill-health that I will most often go to a biomedical practitioner. But this is because, as Hahn later suggests,

the culture of a society *constructs* the way societal members think and feel about sickness and healing. That is to say, the members of a society are taught by others about different sicknesses and their names, their characteristic symptoms and courses, their causes and mitigating circumstances, their cosmological and moral significance, and appropriate responses. What counts as sickness may differ from society to society, and given conditions of sickness are understood in very different ways. [1995: 77]³

My reaction to ill-health is reflective of what I have learned, but as Jean Comaroff points out, healing is "culturally specific self-conscious attempts to mend the physical, emotional and social breaches caused by illness" (1982: 51). "Healing the person," suggests Comaroff, "reaffirms the integrity of an implicit construction of reality and its enveloping symbolic order" (1982: 52). Thus, the use of biomedical categories (disease) cross-culturally, removes the patient from their contexts, which does not aid in understanding medical systems and practices. Rather, all conclusions reached in such cross-cultural analysis will reflect biomedical categories and knowledge, as Kleinman (1998) found in his analysis of depression in non-Western cultures. As Pamela Amoss

Western society" (1988: 682).

suggests, with regards to the use of the biomedical model to explain the Coast Salish Winter Dancing trance experience, the biomedical model “compares aberrant, antisocial behavior from western society with normal, socially useful behavior in the [Coast Salish] system” (1978a: 124). Rubel and Hass suggest that it is a central task for medical anthropology “to find a nonpejorative term with which to describe biomedicine ... so as to be able to compare and contrast that ethnomedical system with others without making a priori value judgments” (1996: 116-117).

Biomedicine as an Ethnomedicine

A solution in medical anthropology to this problem, which includes the biomedicine-ethnomedicine dichotomy, is to suggest, “that Biomedicine is one ethnomedicine among many others,” in that “like all ethnomedicines, [biomedicine] is rooted in cultural presuppositions and values” (Hahn, 1995: 132). But does noting that biomedicine is an ethnomedicine because “it is rooted in cultural presuppositions and values” (Hahn, 1995: 132) overcome the ethnomedicine-biomedicine dichotomy? Or, as I will argue, does it still allude to the possibility of universal biological truths? Does Hahn’s qualification of his “biomedicine as an ethnomedicine” proposal allude to an avoidance of devalorizing biomedicine? In other words, if the association of biomedicine with culture does not connote a devalorization of biomedicine why would Hahn have to state that he “[does] not deny the knowledge or efficacy of this system” (1995: 132)? Does grounding biomedicine in culture question biomedical knowledge or efficacy? If it

³ See also Nancy Waxler’s (1998) discussion of leprosy and the sociocultural construction of illness.

does then Hahn must qualify his statement; but then all other forms of ethnomedical knowledge and efficacy are questioned, because culture is inherent in the concept of “ethnomedicine.” Furthermore, since science, and thus biomedicine, is supposed to be acultural, the suggestion that science and biomedicine are grounded in culture has further implications. Suggesting that biomedicine is grounded in culture implies that there is a “really real” biological reality behind the culturally influenced biomedical model that should, in principle, be open to an acultural scientific investigation (pers. comm., Ingold, 2000). It is the “culture” in science that hinders true access to this “really real” biological reality.

Hahn (1995) is not alone in suggesting we consider biomedicine as an ethnomedicine (see Rhodes, 1996 for a review). For example, in outlining the assumptions of the cultural constructivism approach in medical anthropology, Atwood Gaines states, “research has recently clearly indicated the cultural bases of knowledge and practice in Western Biomedicines (note plural) as well. Therefore, these now may be termed (professional) ethnomedicines of Asia, Europe or North America” (1991: 240; see also Gaines, 1992). Gaines, following E. E. Evans-Pritchard’s “post-functionalist view of society,” envisions ethnomedicines as moral systems not natural systems “and thus are human creations”: “Aspects of medical enterprises are to be seen as culturally constructed and not necessitated in form or function by biology, nature, society or economy” (Gaines, 1991: 241). Michael Taussig makes a similar, and earlier, point arguing

that things such as the signs and symptoms of disease, as much as the technology of healing, are not “things-in-themselves”, are *not only* biological and physical, but *are also* signs of social relations disguised as natural things, concealing their roots in human reciprocity. [1980: 3]

Gaines concludes, “The assumptions of ethnomedicines must thus be seen as cultural assumptions whose form expresses and conceals popular ideas” (1992: 24).

The ethnomedical perspective also views biomedicine as an ethnomedicine. Although this perspective is often considered a subfield of medical anthropology, Mark Nichter argues that this is a simplistic compartmentalization of this field (1992: ix). “Ethnomedical inquiry,” states Nichter, “entails the study of how well-being and suffering are experienced bodily as well as socially, ... and processes of healing as they are contextualized and directed toward the person, household, community and state, land and cosmos” (1992: x). Many other scholars have looked at the relationship between biomedicine and culture (*e.g.*, Comaroff, 1982; Good, 1994; Young, 1976; Zola, 1972). The basic reasoning for the consideration of biomedicine as an ethnomedicine, regardless of theoretical orientation, is best summed up in Hahn’s statement at the beginning of this section: “I claim that Biomedicine is one ethnomedicine among many others, and that, like all ethnomedicines, it is rooted in cultural presuppositions and values, associated with rules of conduct, and embedded in a larger societal and historical context” (1995: 132). But does this perspective overcome the privileging of biomedicine? Does this perspective give equal footing to all medical systems? Has medical anthropology deconstructed the ethnomedicine-biomedicine dichotomy? I argue that it does not, for multiple reasons.

The first set of reasons comes from within medical anthropology theory. Hahn and Kleinman, in an early article, put forth the “biomedicine as an ethnomedicine” statement but then qualify the statement by suggesting that biomedicine is a “unique one”: “Biomedicine, then, is an *ethnomedicine*, albeit a unique one” (1983: 306). In other

words, since biomedicine is a sociocultural system, as are all other forms of ethnomedicines, biomedicine is thus just another ethnomedicine. But Hahn and Kleinman then bestow special status to biomedicine because “it is highly distinctive, contrasting with most traditional, “non-Western” ethnomedicines in fundamental ways” (1983: 322-323). This reasoning for the uniqueness of biomedicine not only gives primacy to biomedicine but also is an ethnocentric conflation of other medical systems — a similar ethnocentrism Hahn and Kleinman criticize the biomedical framework for, with regards to other ethnomedicines (1983: 323). But why is this conflation of other medical systems ethnocentric? As Richard Shweder points out, with regards to objectivity, religion and science,

It is conceivable that the sense of objectivity invested in religious beliefs is not fundamentally different from the sense of objectivity invested in scientific beliefs, and that to describe other peoples’ beliefs as religious or supernatural and our own as scientific is *merely to disguise a prejudice in favor of our own conception of natural law over theirs*. [1986: 170; emphasis added]

Shweder’s point is important for looking at various medical systems. Viewing non-biomedical knowledge as subjective or irrational, through the “gold standard” of biomedical knowledge (Waldram, 2000: 616), is based on a belief in a universal scientific reasoning that has direct access to an objective “nature” and therefore has a universal truth value. Anything that runs contrary to biomedical “truths” is thus either irrational or due to subjectivity. But Shweder points out, similar to what Evans-Pritchard (1937) was earlier trying to show, that what is considered subjective or irrational by outsiders is often considered by insiders as objective and rational:

what looks from the outside like superstition, ideology or supernatural belief, looks from a different perspective, the inside point of view, like an objective inquiry founded, not on

supernatural principles, but rather on a different theory of natural law. What appears from the outside like a faith, a fiction, or a fantasy comes to feel from the inside like a rational enterprise.
[Shweder, 1986: 164]

Thus, the suggestion by Hahn and Kleinman that biomedicine is a unique ethnomedicine is biomedico-centric, asserting that although all the other ethnomedicines are not exactly the same, none of them differ enough to be considered as unique.

The second reason why “biomedicine as an ethnomedicine” does not overcome the ethnomedicine-biomedicine dichotomy is suggested by Nichter:

Many medical anthropologists have noted that biomedicine is a form of ethnomedicine, *but several go on to treat disease as a universal construct in contrast to illness* as an individual’s cultural and idiosyncratic experience of socially devalued states of being.
[1992: xxi; emphasis added]

An example of this can be found in the biocultural perspective in medical anthropology.

As George Armelagos *et al.* state, “following Engel, Fabrega, and Hahn and Kleinman we propose to conceptualize biomedicine as an ethnomedicine” (1992: 40). But, “Western biomedicine provides us with a specific biological and physiological description of disease and illness,” which, “provides information on *very real biological processes* ... that are difficult to observe behaviorally” (Armelagos *et al.*, 1992: 39; emphasis added). Thus the biomedical model, combined with its “relative ubiquity,” “can serve as a common point of comparison” (Armelagos *et al.*, 1992: 39). Hahn, many years ago, exemplified the position that biomedicine provides information on “very real biological processes” by stating that the patient’s theory regarding their ill-health — illness — “may be partly or largely mistaken” (1984: 17). But as Stanley Tambiah points out, “A mistake is something which can be tested and shown to be wrong” (1990: 64). Furthermore, “the idea of testing already implies some particular system which has as its

foundation a set of presuppositions and propositions which cannot themselves be tested or doubted” (Tambiah, 1990: 64). Thus if the patient’s theory (illness) is mistaken, another theory is involved as the criteria of validity, and this other theory “make[s] the activity of questioning possible by determining what will count as evidence for arguments and verification” (Tambiah, 1990: 64). This is exemplified in the biomedical clinical encounter in the translation of the patient’s “illness” into a disease by the practitioner. As Arthur Kleinman states,

illness has particular meanings for practitioners who listen to a patient’s account of illness in light of their own special interests (therapeutic, scientific, professional, financial, personal). Even before the physician entifies an elusive illness into a precise disease, the very ways of auditing the illness account influence the giving of the account and its interpretation. [1988: 52]

Or as Peter Manning and Horacio Fabrega, Jr. state, “What assumes relevance in Western medicine are the person’s complaints, signs, and symptoms indicating that he possesses an altered body, which bear on his condition as medically defined” (1973: 277). In other words the process of diagnosis by the biomedical practitioner only allows certain forms of information, thereby denying information that may be of importance in the patient’s theory. Thus, a patient’s theory can be “mistaken.”

The biocultural perspective has been criticized for this acceptance of scientific and biomedical knowledge because it ignores the cultural influences in this knowledge (*e.g.*, Singer, 1993). Ann McElroy and Patricia Townsend (1996) respond that, although biocultural theorists do privilege biomedical knowledge, this does not mean that they are not cognizant of the sociocultural influences in biomedicine. “Even so,” McElroy and Townsend counter, “medical diagnoses and laboratory analyses are something more than just the ethnomedicine of Western culture. Biomedicine has cross-cultural, universal

applicability when it accurately reflects natural and biological reality” (1996: 67). How to determine when biomedicine does accurately reflect this reality McElroy and Townsend do not tell us. Furthermore, “Whatever its weaknesses, [biomedicine] is a better basis for theory and treatment than theories that reflect the natural sciences” (McElroy and Townsend, 1996: 67). I would like to address two points that McElroy and Townsend’s response to the criticisms of the biocultural perspective raises in the context of my discussion: the first point is with regards to whether the “biomedicine as an ethnomedicine” theorists reject the natural sciences and the second point is the notion of the accurate reflection of a natural and biological reality.

Are McElroy and Townsend incorrect in suggesting that theories not based on biomedical standards reflect the findings of the natural sciences? Maybe, but within the context of the “biomedicine as an ethnomedicine” perspective I am not certain that their suggestion is entirely correct. As the above statement by Nichter informs us: several medical anthropologists who “have noted that biomedicine is a form of ethnomedicine ... go on to treat disease as a universal construct” (1992: xii). Remember from earlier in this chapter that “disease,” as formulated in contrast to “illness,” is the province of biomedicine. These anthropologists then are quite in-line with the biocultural perspective. Also, following on Hahn and Kleinman’s “unique ethnomedicine,” Hahn later qualifies his “biomedicine as an ethnomedicine” proposal by stating, “In describing Biomedicine as a cultural system, I do not deny the knowledge or efficacy of this system. Biomedicine has made revolutionary discoveries and created powerful inventions”(1995: 132). My contention with Hahn’s statement is not in the denial of biomedical knowledge and practices, but that statements such as Hahn’s are only made regarding biomedicine.

Although James Waldram (2000) points out that in fact biomedicine fails to meet its own standards for efficacy, these standards still influence efficacy studies of other medical systems:

The current propensity to employ biomedical concepts and methods, to search for apparent biomedical parallels within traditional medical systems, or to fixate on biomedical terminology that might have intruded into these systems often leads to a false sense of our ability to assess traditional medicine's efficacy. [2000: 619]

Waldram suggests, "Scientific inquiry often leads to the *creation of biomedical artifacts masquerading as universal truths*" (2000: 619; emphasis added). Note how Waldram points to a medical anthropology equivalent of the "indigenous science" notion I discussed earlier in this chapter. My point is that non-biomedical systems are continually being questioned whereas even though biomedicine is questioned at times, some medical anthropologists quickly point out that they "do not deny the knowledge or efficacy of this system" (Hahn, 1995: 132). This qualification by Hahn suggests that he does not abandon the natural sciences. Instead, I argue that this qualification points to, as many of the "biomedicine as ethnomedicine" scholars do, the cultural foundations of science. This leads into my final reason for why the "biomedicine as an ethnomedicine" proposal does not work, and is the second point raised by McElroy and Townsend's response to criticisms of the biocultural perspective. This final reason involves the notion of a "really real" natural and biological reality.

The Dwelling Perspective

The notion of a “really real” biological reality that can be accessed by an acultural scientific investigation has implications for the social sciences. Shweder points out that “objective” nature, studied by the natural sciences, serves as the epistemological ground “from which many social scientists have drawn their ideas about *what kinds of things are really real and really out there*, and how to go about finding them” (1986: 175; emphasis added). Resulting from the cultural influences in biomedicine is a movement to make biomedicine more “scientific” (Gordon 1988a). In the context of clinical biomedicine Deborah Gordon states, “many feel that the process of clinical reasoning or judgement can and should be made more scientific by improving observations, ... eliminating bias, increasing reliability, ... and quantifying the judgement process” (1988a: 264). Thus the problem is, from a scientific viewpoint, not in the fact that science cannot be truly objective, but any cultural, or subjective, incursion into science is due to its lack of scientific rigor: “The hallmarks of science,” proposes Gordon, “— reliability, validity, predictability — are what make something scientific, not the context of research” (1988a: 264).

I argue that this notion of a “really real” (universal) biological reality is embedded in the disease-illness dichotomy, in that disease signifies this “really real” reality on the one hand, while illness signifies the cultural or subjective interpretation of ill-health. Thus we have distinguished two versions of the same phenomenon. This is similar to the paradox described by Tim Ingold with respect to “nature” (1996b: 119): If disease signifies biological processes, it must therefore be a precondition to illness. Disease then, as conceived in Western (“modern”) ways of thinking, involves human beings as

organisms — our “nature” in nature — whereas illness is the lived experience of an individual’s ill-health which is transferred to a supra-biological domain of culture (see Ingold, 1991a, 1996b for similar discussions regarding nature and kinship). Thus, culture becomes a mediating force in which the person’s experience of ill-health is given meaning.

Byron Good points out that “the more fundamental claim from the meaning-centered tradition [in medical anthropology] has been that *disease is not an entity but an explanatory model*. Disease belongs to culture, in particular to the specialized culture of medicine” (1994: 53). I contest this point, not in the sense of denying that biomedicine is a specialized cultural system, as many authors have shown this quite lucidly (*e.g.*, Gaines, 1992; Good and Good, 1993; Gordon, 1988b; Hahn, 1995; Romanucci-Ross and Moerman, 1997), following Clifford Geertz’s various discussions of cultural systems (see Geertz, 1983). What I contest is the ascription of illness and disease to culture. For as Bruno Latour states, in his critique of the critical stance, “Yes, the scientific facts are indeed constructed, but they cannot be reduced to the social dimensions because this dimension is populated by objects mobilized to construct it” (1993: 6). Gordon suggests that the proposed fundamental assumption of “atomism” in biomedicine means that “diseases are considered to have an identity separate from their specific hosts and are located and treated in the “atom” of society — the individual, his/her body divided into parts and parts which are approached as autonomous units” (1988b: 26). Moreover, ““Real” illness corresponds to the degree to which physical traces show up in the body” (Gordon, 1988b: 24). Another related assumption found in biomedicine, suggested by Gordon, is that nature is distinct, and prior, to culture: “Symbols/language/representations

depict an independent empirical reality, rather than constitute it. Meaning is in the correspondence between representation and external reality. Disease taxonomy mirrors nature's "real" diseases" (Gordon, 1988b: 27). This "biologistic" view of the body, and thus disease, in biomedicine is grounded in a presupposition of universality. As Manning and Fabrega suggest, regarding a list of tenets they describe that are "drawn from the biologistic view of the body", "This listing presupposes that the biological structures and functions and the resultant modifications that can be labeled as disease within a biological framework are themselves *universally experienced* as such" (1973: 255). In other words, the biomedical perspective regarding the body and disease is presupposed by a belief in the universality of them. But as Hahn and Kleinman pointed out many years ago, "while connections between these [cultural] realms and Biomedicine are becoming increasingly apparent, still practitioners claim that "medicine" can be delimited as an autonomous domain" (1983: 312).

Since "disease" is viewed as a reflection of "nature's "real" diseases," the natural part of human beings, as I argued above, is considered distinct from the cultural aspect: "Similarly "natural man" is distinct from "cultural man," the "animal of man" is distinguishable from the "human" " (Gordon, 1988b: 27). "This animal/natural part," states Gordon, "is considered universal, the human part — the mind, the spirit — is where diversity shows up. Yet this diversity is really only "skin deep." In fact a common notion is that humans are animals with rationality and culture added" (Gordon, 1988b: 27). This notion of an "addition" is what Ingold has called "animal plus" (e.g., Ingold, 1996b: 130-131). In that as organisms each animal type is distinct from another type so the fact that humans are distinctive is not objectionable. "Yet," suggests Ingold, "we are

inclined to think of elephants and beavers as ‘mere animals’, whereas to be human — we say — is to be more than just an animal,” or one unique animal amongst many, and “the plus factor turns out of course to be that common essence, the ‘capacity for culture’” (1990a: 210).

If culture was a common essence of all persons, the result would be that all persons should have the same culture — which is not the case. What the common essence of humanity is then is not “culture” as a generic notion but a *capacity* for culture which “is supposed to depend on certain general properties of mental functioning” (Ingold, 1990a: 210). Therefore, “[w]hatever humans have in common is accordingly attributed to biology, whereas their differences are attributed to culture” (Ingold, 1990a: 210). As Gordon has suggested with regards to biomedicine,

The cultural dimensions in [bio]medicine are usually seen to be restricted to the superficial, to apply to patients’ behavior and understandings, to exist primarily in “others” beliefs. *Culture is basically external to biology and disease*, just as biology is regarded as essentially universal. [1988b: 28]

Thus biology, in the Western conception, is seen as the location of the baseline ill-health — disease — which “culture” acts upon to create illness, which means, again, that disease presupposes illness.

But if disease belongs to “culture,” as pointed out by Good in the quote above, in particular a “specialized culture”, we run into a problem. If disease and illness belong to culture, and pertain to the same phenomenon, then there should be no difference between the two, thus biomedicine *must* be a cultural system — which, as stated above, I do not contest. But biomedicine cannot be a cultural system as formulated by Geertz (1973, 1983), in the same sense as common-sense, art and religion are, rather, it must be a

specialized one. For, as pointed out earlier in this chapter, disease is the exclusive province of biomedicine (Kleinman, 1988: 5-6), which means if disease does “belong” to culture it is not “culture” in the sense of “Western culture” but a specialized culture, as Good pointed out. But illness cannot “belong” to a specialized culture because “shared illness idioms create a common ground for patient and practitioner to understand each other.... For the practitioner, too, has been socialized into a particular collective experience of illness” (Kleinman, 1988: 5). We have come across another paradox in which disease is both a cultural construct — the specialized culture of biomedicine — *and* a “natural” biological entity.

If the idioms regarding the culturally mediated experience of ill-health (illness) provide a common ground, as suggested by Kleinman above, because “the practitioner ... has been socialized into a particular collective experience of illness” (1988: 5), does this mean that the biomedical practitioner exists in two “cultures”? As Byron Good and Mary-Jo DelVecchio Good showed in their study of Harvard Medical School (1993), medical students are socialized into the specialized culture of biomedicine. So biomedical practitioners have been socialized into two distinct perspectives regarding ill-health — the biomedical and the perspective held toward ill-health before entering medical school. Does this mean that the practitioner jumps back and forth between the two? If these were indeed two separate “cultures,” “and if the characteristics of human nature and the human mind are predominantly culturally determined,” challenges Melford Spiro, “how is it at all possible for an ethnographer to understand a group that is different from his or her own?” (1986: 268) — or in this case how is it possible for a biomedical practitioner to do so? Thus, the disease-illness distinction cannot lie in culture. For, on the one hand as

some medical anthropologists argue, if disease “belongs” to culture then there is no distinction between disease and illness; unless primacy is given to either the biomedical or individual perception of ill-health (which then creates a hierarchy in which, most likely, primacy will be given to the biomedical perception as it provides, at least in theory, the most universally applicable perception). On the other hand, illness cannot “belong” to culture because then illness is presupposed by disease, as I have argued above. Furthermore, Latour argues, “*the very notion of culture is an artifact created by bracketing Nature off*. Cultures — different or universal — do not exist, any more than Nature does” (1993: 104). Latour (1993) proposes the hybrid concept of “natures-cultures” to overcome the false distinction created by the “moderns” between culture, or society, and “nature”, based on the scientific laws of nature. By dissolving the artifact of culture “we discover that the moderns do not separate humans from nonhumans any more than the ‘others’ totally superimpose signs and things” (Latour, 1993: 104). “All natures-cultures are similar,” states Latour,

in that they simultaneously construct humans, divinities and nonhumans. ... If there is one thing we all do, it is surely that we construct both our human collectives and the nonhumans that surround them. In constituting their collectives, some mobilize ancestors, lions, fixed stars, and the coagulated blood of sacrifice; in constructing ours, we mobilize genetics, zoology, cosmology and hæmatology. [1993: 106]

This notion of natures-cultures is similar to what Ingold proposes:

I have argued against the idea that human beings participate concurrently in two distinct worlds, of nature and society, figuring as biological individuals in the former and as cultural subjects in the latter. Instead, I propose that we consider humans as indistinguishably organisms and persons, participating not in two worlds but one. [Ingold, 1998b: 48]

Thus Hahn is not entirely incorrect in his proposal: biomedicine and science are indeed grounded. But not in culture; rather, I contend that they are grounded in experience.

A common notion that continually reappears in the notion of illness is that it corresponds to the *experience* of ill-health. But how then are disease, biomedicine and science grounded in experience? As Ursula Franklin proposes, “Science as well as technology is, after all, more than just a body of knowledge; it is a set of practices and methods. The scientific method as we understand it in the West is a way of separating knowledge from experience” (1990: 38). In other words, Franklin is suggesting that scientific practices and methods separate people from experience. But is this so? Ingold suggests, “that our ideas about the world — *including those that go by the name of science* — are fashioned against the background of our active engagement with its diverse human and nonhuman constituents” (1997b: 232). Furthermore, Spiro suggests that insight and imagination, as techniques of inquiry, are key to research in not only the human sciences but also in the physical sciences:

If not by insight and imagination, how else might an investigator, whatever the subject of inquiry, arrive at a hypothesis — a guess, a hunch, a speculation — regarding the proper explanation or interpretation of his observations and data? Indeed, how else could certain kinds of data be obtained, if not only by means of those same techniques? [1986: 274]

Spiro suggests this latter point may apply more to the human than the physical sciences. But is this so? Ingold points out that the knowledge a person gains by being actively engaged with the world (which Ingold refers to as “intuition”) “constitutes a necessary foundation for any system of science or ethics,” for, “an intelligence that was completely detached from the conditions of life in the world could not think the thoughts it does” (1998a: 178).

Furthermore, and much earlier than Ingold, Edmund Husserl stated that all objective theory is rooted in the life-world and this rootedness is what gives meaning to objective science:

objective theory in its logical sense... is rooted, grounded in the life-world, in the original self-evidences belonging to it. Thanks to this rootedness objective science has a constant reference of meaning to the world in which we always live, even as scientists and also in the total community of scientists — a reference, that is, to the general life-world. [1970 [1954]: 130]

This notion of the “life-world” (*Lebenswelt*) introduced here by Husserl is important for my discussion. “The life-world,” states David Abram, “is the world of our immediately lived experience, as we live it, prior to all our thoughts about it” (1996: 40). Part of the reason why this notion is important is that I find it quite similar to the notion introduced by Ingold called the “poetics of dwelling” (1998a). The “poetics of dwelling” is synonymous with the “dwelling perspective” in that they are versions of the same notion. Ingold uses the term “poetics” to emphasize that what is entailed in this notion is not an alternative way of knowing, but a way of being that is fundamental to any mode of knowing (pers. comm., Ingold, 2000). A related notion to Husserl’s “life-world,” and the philosophical basis of Ingold’s dwelling perspective⁴, is Martin Heidegger’s notion of “being-in-the-world” (*Dasein*). Similar to Husserl, Heidegger’s notion also conceives of human beings as inseparable from the world (see Gooch, 1998: 305). As Pernille Gooch suggests, regarding Heidegger’s conception of humans as compared to the Cartesian, disembodied subject, “For him, humans are concrete beings and not mere consciousness. Their world is a concrete, everyday world, *a life-world in which humans dwell*” (1998: 305; emphasis added). Being-in-the-world is achieved through a person’s engagement

with the world, and this engagement is what Heidegger calls “dwelling” (1993; Gooch, 1998: 305). The notion of dwelling is key to knowledge as Martin Heidegger points out, “Dwelling ... is *the basic character of Being*” (1993: 362; see also Heidegger, 1971: 215), or as Ingold argues, “Only because [people] already dwell [in the world] can they think the thoughts they do” (1995: 76).

Donna Haraway (1991) has also discussed this notion of knowledge as grounded in experience discussed by Heidegger, Husserl and Ingold, as “situated knowledge.” Haraway describes situated knowledge in the context of her discussion of vision (1991: 188ff.). Vision appears to have dual connotations: first as an embodied sensory system and secondly, as suggested in her use of the Foucauldian notion of the “gaze,” as representing the scientific enterprise (see Gram-Hanssen, 1996). This second sense of vision “has been used to signify a leap out of the marked body and into a conquering gaze from nowhere” (Haraway, 1991: 188). Haraway utilizes the notion of “situated knowledge” to propose “a doctrine of embodied objectivity that accommodates paradoxical and critical feminist science projects” (1991: 188). But as Kirsten Gram-Hanssen points out, “When Haraway uses the word ‘objective’, it is obviously not in the positivistic sense of the word” (1996: 92). As Haraway writes, “I want to argue for a doctrine and practice of objectivity that privileges contestation, deconstruction, passionate construction, webbed connections, and hope for transformation of systems of knowledge and ways of seeing” (1991: 191-192). Scientific objectivity is a “god-trick” which has allowed the “myth” of the scientific gaze to be put into practice (Haraway, 1991: 189). Furthermore, this scientific gaze, along with all other types of vision, are not

⁴ Ingold writes that Heidegger’s essay, *Building Dwelling Thinking* (1993), provides “the founding statement of the dwelling perspective” (1995: 76).

passive. Instead, Haraway argues, “that all eyes ... are active perceptual systems, building in translations and specific *ways* of seeing, that is, ways of life” (1991: 190). Moreover, Haraway argues that “positioning” is key in the grounding of knowledge: “Positioning is, therefore, the key practice grounding knowledge organized around the imagery of vision, as so much Western scientific and philosophic discourse is organized” (1991: 193). For Haraway, vision and rationality are interrelated: “Struggles over what will count as rational accounts of the world are struggles over *how* to see” (1991: 194). As Michel Foucault describes regarding the reorganization of the medical gaze in the 19th Century:

But the medical gaze was also organized in a new way. First, it was no longer the gaze of any observer, but that of a doctor supported and justified by an institution, that of a doctor endowed with the power of decision and intervention. Moreover, it was a gaze that was not bound by the narrow grid of structure (form, arrangement, number, size), but that could and should grasp colours, variations, tiny anomalies, always receptive to the deviant. Finally, it was a gaze that was not content to observe what was self-evident; it must make it possible to outline chances and risks; it was calculating. [1991: 89]

This reorganization of the medical gaze placed biomedicine in a dominant position in the struggles over rational accounts of the world, as mentioned by Haraway above.

I find Haraway’s notions of “situated knowledge” useful in that it highlights the engagement with, or experience of, the locality. Furthermore, the “positioned” aspect of this knowledge, in that it only provides a partial view, is also an important feature of Haraway’s notion. But I find her “situated knowledge” is more concerned with issues of gender, race, colonialism and hegemony in science and biomedicine, and although these are all important in the construction, and reproduction, of knowledge, my use of situated knowledge is, as stated above, more concerned with the situatedness of knowledge in the

engagement of lived experience in the world. My concern here is not with pointing out faults in science or biomedicine, although my arguments run similar to other arguments concerned with such matters. Instead I am trying to show how science and biomedicine are one way of engaging the world — one amongst many. As Good points out,

The scientific world is only one of several worlds or “subuniverses” in which we live, worlds which include those of religious experience, of dreams and fantasies, or music and art, and of the “common-sense” reality which is paramount in much of our lives. [1994: 122]

Good continues, “These are not simply forms of individual experience, but diverse worlds, with distinctive objects, symbolic forms, social practices, and modes of experience” (1994: 122). Science and biomedicine may have problems with racism and domination but this does not invalidate them as modes of engagement. Am I promoting a strong form of relativism (see Spiro, 1986 for a review of the various forms of relativism)? Possibly, but as Geertz points out,

The fear of relativism, ... has led to a position in which cultural diversity ... amounts to a series of expressions ... of a settled, underlying reality, the essential nature of man, and anthropology amounts to an attempt to see through the haze of those expressions to the substance of that reality. [1984: 272]

We have come full-circle back to the notion of a “really real” reality, and this fear of relativism, discussed by Geertz, invokes the emic-etic distinction, which, in the case of medical anthropology, is embodied in the disease-illness dichotomy.

Haraway’s notion of “positioning” in knowledge discussed above is important in relation to knowledge and the life-world. Good points out that the life-world “is often contrasted with the objective world of the sciences, and many assume that the latter represents reality in the strict sense of the word” (1994: 122). But as Husserl states,

“Objective science, too, asks questions only on the ground of this [life-world’s] existing in advance through prescientific life. ... [O]bjective science presupposes the being of this [life-world]” (1970 [1954]: 110). Gregory Bateson also argues that science is based on presuppositions, as are art, religion, commerce and warfare. “It differs, however from most other branches of human activity,” Bateson states of science, “in that not only are the pathways of scientific thought determined by the presuppositions of the scientists but their goals are the testing and revision of old presuppositions and the creation of new” (1979: 25). Good furthers this point of science’s grounding in the life-world by highlighting the situatedness and positioned-ness of science: “[Science] assumes a particular perspective, a particular attitude to be taken toward reality, and it constitutes distinctive forms of knowledge” (1994: 122). “[B]ut,” Good suggests, “[science] presupposes dimensions of experience and its interpretation common to the lifeworld” (1994: 122).

These different forms of knowledge, as Good points out above, are important in the contrast between scientific (and biomedical) knowledge and other forms of knowledge. This contrast is often based on epistemological grounds, such as in the disease-illness distinction or in the use of biomedical standards in the biocultural approach in medical anthropology. This epistemological contrast, between biomedical and ethnomedical knowledge is firmly grounded in notions of modernity.

Ingold proposes two contrasting understandings of traditional knowledge, which he calls, in short, MTK and LTK (see Ingold, 1997c; 2000a; and Ingold and Kurttila, 2000). MTK, defines Ingold, is “[traditional] knowledge as constituted within the language and idioms of modernity;” while LTK, on the other hand, signifies “traditional

knowledge as generated and sustained within the practices of locality” (Ingold, 2000a: 1).

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contend that the construction of ‘indigenous knowledge’ (MTK), through its opposition to modern science, implies a sense of what it means to know that *dis*-places the knower, and that is incompatible with ways of knowing (LTK) that are constitutive of locality. [2000: 184]

These two understandings of traditional knowledge are not separate forms of knowledge that one can then compare. Instead, Ingold and Kurttila attempt to show “the idea that people’s experience is organized in terms of shared concepts that are transmitted through their education in a particular culture belongs, fair and square, within the modernist discourse on traditional knowledge” (2000: 184-185). “To compare LTK and MTK in such terms,” they continue, “would be to confirm rather than challenge the hegemony of this discourse” (2000: 185). Challenging the modernist discourse is important in cross-cultural comparison and relativism, because as Latour points out, “at the heart of the question of relativism we find the question of science” (1993: 97). Furthermore, Latour argues, “It is the transcendence of science — conflated with Nature — that makes it possible to relativize all cultures, theirs and ours alike” (1993: 98). “[W]ith the one caveat, of course,” Latour states, “that it is precisely our culture, not theirs, that is constructed through biology, electronic microscopes and telecommunication networks” (1993: 98). Thus Ingold proposes LTK; and, moreover, shows why the “biomedicine as an ethnomedicine” proposition does nothing to overcome the hegemony of biomedical knowledge. I will discuss this in further detail in a subsequent chapter, but my point here is that simply stating that biomedicine is grounded in culture, like any other medical system, does not necessarily overcome the dichotomy of medical systems. For as

Latour's caveat states, "it is precisely our culture, not theirs, that is constructed through biology" (1993: 98). This is how Hahn and Kleinman's (1983) description of biomedicine as a "unique" ethnomedicine has gone relatively unchallenged.

If, on the other hand, we look at knowledge as LTK, as knowledge that "is continually generated and regenerated within the contexts of people's skilled, practical involvement with significant components of the environment" (Ingold, 1997c: 9), do we not, then, challenge the hegemony of the modernist discourse? By viewing knowledge as LTK, Ingold and Kurttila propose that scientific knowledge is a form of LTK:

In their work, scientists engage in certain environmentally emplaced, observational practices, just as much as local people do. In each case, knowledge grows out of this engagement. In short, science is itself a form of LTK: it is both traditional in its mode of reproduction and engendered in the practices of locality. [2000: 195]

Ingold suggests that any judgment that has no grounding in experience "however justified it might be on grounds of 'cold' logic, would carry no practical or motivational force whatever" (1998a: 178). "Where the logic of ethical reasoning, setting out from first principles," Ingold continues, "leads to results that are counter-intuitive, we do not reject our intuitions but rather change the principles, so that they will generate results which conform more closely to what we *feel* is right" (1998a: 178).

Before continuing, a brief discussion of what is connoted by this usage of "locality" is needed. With regards to knowledge, "local" is not in opposition to "global"⁵ in the sense that local knowledge is tied to place. Rather, Ingold and Kurttila suggest that "knowledge is local because it inheres in the activity, of inhabiting the land, that actually

⁵ "Global" and "local" will be discussed in further detail in chapter 4.

creates places” (2000: 194).⁶ As Heidegger has pointed out, locales come into existence through dwelling (1993: 359). Heidegger writes, for example, “Because what we signify when we say “on the earth” exists only insofar as man dwells on earth and in his dwelling lets the earth be as earth” (1971: 227). A person is “local” through this activity of creating places (dwelling): “And in creating places, it also makes the inhabitants people of those places — it makes them local” (Ingold and Kurttila, 2000: 194). In other words, it is through the creation of places or locales that knowledge and people are local — this is what LTK embodies and this is part of what I am attempting to show in this thesis.

As stated above, Spiro discusses the indispensable role of insight and imagination as techniques in the scientific enterprise. “Nevertheless,” Spiro states, “however indispensable those subjective procedures may be for the formulation of interpretations and explanations, in the scientific mode of inquiry they are entirely disqualified as a method for their validation” (1986: 274). This use and subsequent discrediting of the “subjective procedures” reflects Husserl’s point

that there are two sorts of truth: on the one side, everyday practical situational truths, relative, to be sure, but, ... exactly what praxis, in its particular projects, seeks and needs; on the other side there are scientific truths, and their grounding leads back precisely to the situational truths, but in such a way that scientific method does not suffer thereby in respect to its own meaning, since it wants to use and must use precisely these truths. [1970 [1954]: 132]

Thus the problem is not cultural influences, or the denial of the influences, in science and biomedicine, but it is in the discrediting of experience and the role it plays in scientific inquiry. The former type of truth discussed by Husserl, and its relationship to the latter type, is why Haraway’s point about how knowledge is positioned/partial is useful. The

⁶ Good makes a similar point suggesting that “meaning and knowledge are always constituted in relation to such worlds of experience” (1994: 177).

partiality of scientific knowledge is a result of what is allowed to be, and serve as, “fact”: “We know the nature of the facts because we have developed them in circumstances that are under our complete control” (Latour, 1993: 18). The controlled nature of facts is illustrated in the diagnostic process: “[The patient’s] mode of relating to the world is reduced to those facts that are directly relevant to the scientific purposes at hand” (Manning and Fabrega, 1973: 277).

Although Husserl’s “practical situational truths” form the foundation for the “scientific truths,” Franklin argues, contrary to Good, “Today scientific constructs have become *the* model of describing reality rather than *one* of the ways of describing life around us” (1990: 39). “As a consequence,” she continues, “there has been a very marked decrease in the reliance of people on their own experience and their own senses” (1990: 39). Geertz has put forth a similar point: “The development of modern science has had a profound effect — though perhaps not so profound as sometimes imagined — upon Western common-sense views” (1983: 86-87). Geertz takes the example of a television commercial to demonstrate this effect, with regards to the germ theory of disease. “But,” Geertz cautions, “as the merest television commercial also demonstrates, it is as a bit of common sense, not as an articulated scientific theory, that [the individual] believes it” (1983: 87). But is this effect of science on common-sense and experience as totalizing as some authors suggest? For example, Abram suggests that science and technology have begun “to blindly overrun the experiential world — even, in their errancy, threatening to obliterate the [life-world] entirely” (1996: 41). Geertz, though, points out that common-sense, as a cultural system, is historically situated and thus is subject to the standards of judgment of the time:

If common sense is as much an interpretation of the immediacies of experience, a gloss on them, as are myth, painting, epistemology, or whatever, then it is like them, historically constructed and, like them, subjected to historically defined standards of judgment. [1983: 76]

If common-sense is based on experience and is historically situated, can one then conclude that science, biomedicine and technology are distorting our common-sense and experience? I argue that they do not. If science, biomedicine and technology can be said to “distort” or “overrun” reality or the experience of it, whether rhetorically or literally, it would follow that there is a “really real” reality. This “really real” reality must then, presuppose science, biomedicine and the individual’s experience. The implication of this is that we now have four hierarchically arranged versions of reality. First, as just discussed, there is the “really really real” reality that presupposes science and the person. The next reality is the objective “really real” reality that science and biomedicine, in theory, supposedly explain. Third, is the culturally grounded “really real” reality that scholars discussed above suggest science and biomedicine study. And finally, there is the subjective, experiential reality of the individual.

These divisions of reality reflect the emic-etic distinction in anthropology in which we have a hierarchical layering of realities with the top one being the most general in applicability and corresponding to the acultural scientific and biomedical perspectives (as does the etic perspective). As we progress through this layering, the level of subjectivity increases until we have reached the innermost layer — the subjective, individual perspective — which corresponds to the emic perspective. But the correspondence of this hierarchy with the emic-etic distinction “implies an initial separation of mind from world” (Ingold, 1999: xi; see also Ingold, 1998a: 161-163). This

separation reflects, and thus reinforces, the (dominance) of the Western scientific and biomedical perspectives. To consider medical practices and systems in an equal way, one must do so at the level of experience of, or engagement with, the world. In the next chapter I will discuss a healing ceremony (*sbəłtədaq*) that was formerly practiced by the Coast Salish people of the Puget Sound region (see Map 1), as an example of how medical practices represent a mode of LTK that also reflects and reinforces the way these people experienced and engaged the world.

CHAPTER THREE: The *sbəłtədaq* Ceremony

As mentioned in the introduction, the *sbəłtədaq* ceremony is no longer practiced by the Coast Salish people in the Puget Sound region. But the passing of the ceremony does not mean that the concerns it addressed do not remain. Rather, Jay Miller suggests that these concerns have found other outlets (1999b: 144). Miller writes at the end of his book *Lushootseed Culture and the Shamanic Odyssey* that there is an oft-heard saying among the Coast Salish on the eastern side of the Puget Sound concerning old and new traditions — “The biggest tree has the deepest roots” (in Miller, 1999b: 146). This echoes Ursula Franklin’s point with reference to the historical roots of technology: “The reason for dwelling on historical situations is that patterns do have very deep and profound roots” (Franklin, 1990: 61). Traditions found today among the Coast Salish have roots in the *sbəłtədaq* ceremony. With regards to the *sbəłtədaq* ceremony, these roots bind people, health, ancestors and the world together, providing the individual with an avenue “to get the feel of the country, and a sensitive appreciation of the beings that dwell in it” (Ingold, 2000a: 4). It is in this chapter that I will discuss how this ceremony’s roots bind all of these things together and how the ceremony reflects and reinforces a particular mode of engagement with the world.

This chapter is based on historical literature which has been problematic at times. There has been no overall description of the ceremony, and published analyses of the ceremony and its variations have been derived from first-hand accounts¹ by writers

¹ There is one exception to this, where in 1920 a group of men who belonged to the Indian Shaker Church performed a mock version of the ceremony using planks 2/3 of the size of the ones used when the ceremony was performed (Miller, 1988: 20; Suttles and Lane, 1990: 499; for a discussion of the Indian Shaker Church and the differences with the shamanistic religion see Amoss, 1978b).

(Miller, 1988: xvi), or on reaccounts of it by informants (Dorsey, 1902: 234; Haeberlin, 1918; 249). In my discussion of the ceremony I rely heavily on Miller's analysis of the recounted ceremonies (1988, 1992, 1999b), as this work provides the most recent and in-depth accounts. Miller has access to information that I was unable to attain, and to a greater breadth of information, that adds to his analyses. Although I do rely heavily on Miller's work, my purpose for discussing the ceremony differs which leads me to highlight different aspects of the ceremony and to some different conclusions. Some accounts dealing specifically with of the ceremony have been published (*e.g.*, Dorsey, 1902; Haeberlin, 1918). Along with T. T. Waterman's (1930) account these serve as a basis for both Miller's and my discussion of the ceremony. My analysis has also been supplemented by information regarding the ceremony that was recorded during larger research projects on the Coast Salish by William Elmendorf (1935; 1960; 1993), Miller (1999a), Jay Miller with Warren Snyder (1999), and by Marian Smith (n.d.; 1940).

One problem that arose in looking at intergroup variations in the ceremony is because where Waterman collected his information and to whom he attributes his information to do not match. As Miller writes, "Waterman collected his data at Tolt (now Carnation) and Marysville, both of which he identified as Duwamish. Actually, Marysville (Tulalip) was Snohomish territory and Tolt was an important Snoqualmie community, so his data need to be considered accordingly" (1988: 14). Waterman does not identify which information comes from which group, so analysis is hindered. Herman Haeberlin's account (1918) is similar in that Haeberlin does not identify which information comes from which group that he worked with. In table 1, below, I list all of

the main sources I referred to regarding the *sbəltədaq* ceremony, and note which group each source is derived from.

Source	Group(s)
Dorsey (1902)	Duwamish
Elmendorf (1960)	Twana
Elmendorf (1993)	Skokomish Twana
Haeberlin (1918)	Snohomish
	Puyallup
	Nisqually
Miller (1999a)	Chehalis
Miller with Snyder (1999)	Snoqualmie
Smith (n.d.)	Snoqualmie
	Suquamish
Waterman (1930)	Duwamish (?)
	Snohomish (?)
	Snoqualmie (?)

Table 1: Sources and groups referenced regarding the *sbəltədaq* ceremony.

The notion of a soul recovery ceremony is, or was, present “among most of the native peoples throughout a rather extensive area on the northwest coast of North America” (Elmendorf, 1935: 1). William Elmendorf, in a forgivable bias toward the subject of his own interest, finds that among the Coast Salish in the Puget Sound this type of ceremony was “found in its most elaborate and specialized forms” (1935: 1). The Puget Sound version of the soul recovery ceremony was called, in English, the “Spirit Canoe ceremony” in the classic literature (e.g. Waterman, 1930). However, as Jay Miller points out,

In the anthropological literature, this ritual is known as the Spirit Canoe or Soul Recovery ceremony, but neither of these is an appropriate translation of the Lushootseed name, varying among the dialects as *sbětətda’q* in the north and *sptadaq* in the south. [Miller, 1988: xv]

*sbəłtədaq*², the Skagit or Northern Lushootseed word for the ceremony, translates as “shamans curing in a row,” “indicating that a trajectory of shamans intends to cure their patient by recovering his or her absent spirit” (Miller, 1988: xv-xvi; pers. comm., Miller, 2001). One possible reason for the mistranslation of *sbəłtədaq* lays in the Lushootseed word *qilbid*, which Miller (pers. comm., 2001) heard used in the descriptions of the ceremony. T. T. Waterman and Geraldine Coffin found that *qilbid* was the general word for canoe (1920: 22). But *qilbid* is one of two general words in Lushootseed that can refer to a canoe (Miller, 1999b: 107; Bates *et al.*, 1994: 185, 203). The important difference between the two general words is that *qilbid* refers to any kind of vehicle (Bates *et al.*, 1994: 185). Canoes were an important form of transportation and *qilbid* is one word that would most likely have been used to refer to canoes during the period that data was being collected on the *sbəłtədaq* ceremony (Miller, 1988: 83). With the use of *qilbid* to refer to both canoes and the vehicle which transported the shamans to the land of the dead, it is understandable that early researchers assumed that the word referred to, in both cases, a canoe. This possible explanation may also help T. T. Waterman with his confusion in his analysis of the ceremony: “Why people who are *in* a spirit-boat should have to make a boat all over again is a point about which my informants did not concern themselves” (1930: 139). Miller points out in his review of the various accounts of the ceremony, “a symbolic canoe was neither a constant feature of [the ceremony], nor the sole means of transport” (1988: 83; e.g. among the Puyallup-Nisqually most of the journey was done by foot, (see Smith, 1940: 98-99). Thus, the name “spirit canoe ceremony” is not adequate.

² When possible I will write Lushootseed words in the contemporary orthography adapting the original author’s spellings (see Bates *et al.*, 1994 for current orthography and see also Miller, 1988: 197-198 for corrections to Waterman’s (1930) terms).

Neither is “soul recovery” an effective name, as the doctors³ performed the ceremony to recover at least three things: soul, mind, and/or guardian spirit/ally. Referring to the ceremony only as “soul recovery” leaves out the other two aspects of the ceremony (pers. comm., Miller, 2001).

The *sbəłtədaq* ceremony had important implications for the groups which practiced it, since the ceremony “brought together every aspect of Lushootseed culture” (Miller, 1999b: 135). Before delving further into the relationship between the *sbəłtədaq* ceremony and the cultures in which it was practiced, a description of the ceremony is appropriate to prepare the platform for the subsequent analysis.

The *sbəłtədaq* Ceremony

The ceremony involved a group of shamans journeying to the land of the dead (Waterman, 1930). Usually the group consisted of eight shamans, but, according to Herman Haeberlin, the size of the group was always an even number and ranged between six and twelve (1918: 251; cf. Smith, n.d.; Miller, 1992: 8). It has been suggested that the number of shamans was always even for purposes of maintaining balance (Miller, 1992: 8), but an even number of shamans is not found in all of the accounts of the ceremony. For example, in one of the Suquamish accounts, a shaman would be asked to cure the patient who would in turn choose at least two more shamans to assist in the journey (Miller with Snyder, 1999: 154). The notion of having an even number of shamans for balance in later accounts and analyses may be derived from Haeberlin’s account of the

³ “Shamans” and “doctors” are used interchangeably to refer to Coast Salish healers.

shamans standing in two rows, in which Haeberlin may have incorrectly interpreted that the shamans formed the crews of two canoes (Haeberlin, 1918: 252-253; *cf.* Waterman, 1930: 540-542). Waterman does suggest, “Probably Haeberlin was describing a more ambitious ceremony, in which more shamans were employed and in which they accordingly divided themselves into two crews” (1930: 542). Yet, even if the shamans were divided into two crews, the literature on the ceremony indicates that the shamans in Haeberlin’s account were still using only one *qilbid*. Regardless, the purpose of the journey, as stated above, was to retrieve a person’s soul, mind or guardian spirit/ally that had been stolen by inhabitants of the land of the dead (pers. comm., Miller, 2001; Waterman, 1930: 131). These three (spiritual) aspects of a person are considered by the Coast Salish people to be essential to the health of the individual (Miller, 1988: 85; *cf.* Amoss, 1978a: 43). The symptoms that suggested an individual needed the ceremony performed included what June Collins and Elmendorf described as “prolonged illnesses”⁴ (Collins, 1974: 202; Elmendorf, 1993: 233) or what is translated as “lethargy” in Coast Salish terms. “Lethargy,” in this usage, connotes a semi-catatonic state in which the individual wastes away without any resistance, displaying a helpless, unmotivated and inattentive behaviour (pers. comm., Miller, 2001).

The ceremony proper can be divided into three basic components: “the journey down [by the travelers], a contest with the ghosts, and a return, which included delivery of the soul to the patient” (Waterman, 1930: 144). Although Waterman states that the first component was “the journey down,” the notion that the journey was downward (or downriver) is not fully agreed upon. Most of the earlier authors (e.g. Dorsey, 1902;

⁴ In this chapter I am not making any distinction between disease, illness, sickness etc., as I am only concerned here with the Coast Salish notions of ill-health.

Frachtenberg, 1920; Wickersham, 1898) are in agreement with Waterman's assertion but these authors may all be guilty of the same misunderstanding. As Haeberlin states, "the land of the dead was thought to lie in the west. While the trail that led to it descended, I was told expressly that it was not below this world in the sense of being an "underworld," but that it was on the same level with this world" (1918: 253-254). Haeberlin's statement is supported in later analyses by both Miller (1988, 1999b) and Marian Smith (n.d.: MS268:5:2 no. 30).

Waterman suggests that the ceremony usually took about five days, and he "never heard of a ceremony lasting less than two nights" (1930: 144; *cf.* Elmendorf, 1993: 233; Miller, 1992: 9-10). Waterman also suggests that "[t]he time occupied in reaching the underworld depended somewhat on the amount of money the patient could afford to pay" (1930: 143-144). But, due to some of the beliefs surrounding the ceremonial paraphernalia, it took up to twelve days to complete preparations for the journey (Waterman, 1930: 144; see also Miller, 1999b for a discussion of the preparations). The majority of the ceremony consisted of the journeying to the land of the dead, as often a short cut was used on the return trip (Miller, 1992: 12; *cf.* Elmendorf, 1993: 236; Smith, n.d.: MS268:5:2 no. 30). The ceremony mainly took place inside of a plank house that was "either owned by the patient or one borrowed for the occasion" (Miller, 1999b: 135; Haeberlin, 1918: 252). "The entire journey to the underworld," states Miller, "might be undertaken in the house and adjoining lands" (1992: 9-10; *cf.* Smith, 1940: 99). The area surrounding the house is involved in the ceremony as well; in some cases when the party

was nearing the first land of the dead the shamans in this world acting out the journey⁵ would at times move over to the nearest human graveyard (Miller, 1992: 11-12).

Before the ceremony began the shamans would gather to make and paint the planks (one of the three sets of ceremonial objects used) that would form the metaphorical vehicle used in the journey⁶. Paul Wingert suggests that these painted planks, and the carved figures to be discussed shortly, are excellent examples of the representational style of painting that is unique to and characteristic of Coast Salish art in the Puget Sound (Wingert, 1949: 78). These two types of ceremonial objects are excellent examples of the Salish representational art style, in that “[t]hey were all made and painted to demonstrate and to use the particular power possessed by an individual” (Wingert, 1949: 78). Thus, unlike the monochrome and descriptive art styles⁷ found throughout the Pacific Northwest Coast, the style of painting used for the boards is representation of an individual’s power as it would appear to them (Wingert, 1949: 77; see Waterman, 1930: 301-312 for examples, and discussion of the figures painted on the boards). Moreover, the painted boards, Wingert proposes, provide us with “the most important examples of Salish painting” (1949: 79). The boards that still remain, stored at various museums (see Miller, 1988: 51-82 for a full review and Wingert, 1949: 79 for a brief review of where the specimens are kept), are all basically identical in shape (Wingert, 1949: 79); although Waterman suggests, “at least three forms can be distinguished” (1930: 295; see also Haeberlin, 1918: 253). The shape of each board can be roughly divided into three

⁵ This will be discussed in further detail later in this chapter.

⁶ Although not all groups used the planks or a vehicle it seems that the majority of groups, at a minimum, used a vehicle of some sorts, which was often constructed with planks (Elmendorf, 1935; Miller, 1988).

⁷ Wingert writes that the monochrome art style was found mainly among the Quinault in western Washington in which “power figures and boards were ... painted in red or black” (1949: 77). In the descriptive art style is where “details already described by the sculptor were emphasized in several colors, usually red and black” (Wingert, 1949: 77).

segments: the base, middle, and top of the board. The base was unpainted and V-shaped so it could be inserted into the ground (Dorsey, 1902: 228; Wingert, 1949: 79). The middle portion consisted of “a long vertical form, resembling roughly a truncated ovoid, the one side less curved than the other” (Wingert, 1949: 79). This section of the board would have a base coat of white, over which each participating shaman would paint their guardian spirit power in black, red, and/or white (Waterman, 1930: 295-296; Smith, n.d.: MS268:5:2 no. 30). These three primary colours (black, red and white) used to paint the boards and the other paraphernalia of the ceremony are still found in the contemporary Coast Salish religious practice called Winter Spirit Dancing, or *syuʔwən*⁸ in Lushootseed (see Amoss, 1978a for a comprehensive discussion of *syuʔwən*; see also Suttles, 1987d).

In *syuʔwən*,

dancers are also divided into basic types distinguished by black paint or red paint, each having distinctive songs and spirits. ... White paint lacks any special associations at present, but older sources indicated that there were white paint dancers in ancient times who were renowned shamans. [Miller, 1988: 94-95]⁹

With regards to the top section, Wingert states that it consists of “a small projecting head- or snout-like form, the top of which continues the curve of the “back” of the form below” (1949: 79). An important belief regarding the painted planks was that they were used only once, except under the most dire circumstances, so to close the route the shamans took back to the land of the living “[t]he planks were taken into a remote area of the woods to rot and return to their elements. ... Having made the journey once, the boards were considered contaminated and unsafe” (Miller, 1992: 13; see also Wingert, 1949: 79).

⁸ This is also referred to variously as “Winter Dance,” “Spirit Dance,” or “Winter Spirit Dance,” and in older sources by the general Chinook jargon phrase, “dancing tamanous” (e.g. Eells, 1985).

Carved humanoid figures formed another of the sets of ceremonial objects used in the ceremony. These figures stood from three to four and a half feet tall and were painted anew for each ceremony. They were the only objects in this ceremony that were always reused (Miller, 1992: 9, 13; Waterman, 1930: 535). These figures represented primordial forest spirits called “Little Earths,” or *swaw̓tix̓ʔtəd* (Miller, 1999b: 136; Bates *et al.*, 1994: 245). In actuality it was these Little Earths that journeyed to the land of the dead, while the shamans remained in the house acting out the voyage for the spectators (Miller, 1999b: 136). Many authors suggest that having a Little Earth as a guardian spirit power conferred the ability to perform this ceremony (e.g. Miller, 1988: xviii; Smith, n.d.: MS268:5:2 no. 30; Waterman, 1930; *cf.* Collins, 1974; Elmendorf, 1960, 1993; Miller, 1999a: 50).

The final ceremonial object used in the *sbəltədaq* ceremony is called *təstəd* (ceremonial staff or pole). *təstəd* were used for various functions during the ceremony — such as a bow, punt, probe, spear, or paddle — depending upon how the journey was undertaken (e.g. on foot or by vehicle) and where the shamans were on the journey (Miller, 1999b: 136; Waterman, 1930: 539-540). The *təstəd* are also considered to be spiritual siblings of the *sg̓ədilič* boards, both having fairly similar functions (Miller, 1988: 94). *təstəd* are also used in *syuʔwən* ceremonies.

Once these objects were assembled and prepared, the ceremony proper could begin. Spectators would be seated inside the house along the walls, sitting very still and quietly while the patient would be resting on a cedarbark mat at the rear of the house. The group of shamans, and their helpers, would gather outside of the house, lining up to

⁹ See also Jenness, 1955: 41 for a discussion of paint colours.

march in and set up their ceremonial objects (Miller, 1992: 9, 1999b: 136-137). Then, the shamans entered:

Surrounded by drumming and singing, the procession entered the house. The shamans were wearing special cedarbark headbands and painted faces. ... Each curer carried his Little Earth, with an assistant carrying the painted plank. Sometimes, the planks were held so that they appeared to peek inside the door, making their power seem more lifelike. The shamans placed their figurines in a line down the center of the house and sat down on the sidelines. Helpers arranged the planks in pairs so that each shaman faced an image of his own spirit power painted on the middle of the plank ahead of him. [Miller, 1999b: 137]

The painted planks that served as a way to protect the shamans and their placement inside the house were probably what led early authors to conclude that the *qilbid* was some sort of canoe. The painted planks were set into the ground with one at each end, forming the bow and stern in the case of a canoe, while the remaining planks were set in two rows on either side of the end planks (see figure 1). The end planks were only painted on one side while the middle planks had both sides painted. “In this manner,” states Miller, “the images looked at each other and provided protection for the shaman both front and back” (1999b: 137). When the shamans began singing, as they departed, the Little Earths would hear them and would come running “into the house to help out by lodging in their carved effigies” (Miller, 1999b: 136) and the journey began.

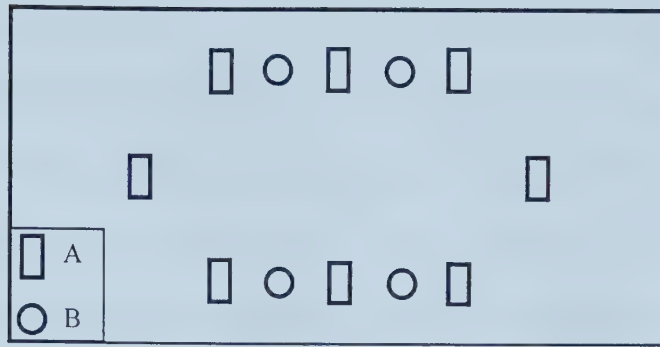


Figure 1: *Placement of the paraphernalia for the sbəltədaq ceremony. The rectangles (A) represent the painted boards; the circles (B) represent the Little Earth figures.*

The trail to the land of the dead passed through eight major locations (see figure 2). The first location ventured upon by the travelers, was *sqəlalitutdup*¹⁰, ceremonial-object place, which was “filled with the spirits of artifacts, each of which sang its song” (Miller, 1999b: 137; Waterman, 1930: 137). The sort of artifacts that were found in this location were: baskets, arrowpoints, parts of canoes, and pack-straps (Waterman, 1930: 137-138). The shamans would learn the songs sung by the objects so they could be brought back (Miller, 1999b: 137).

sqəlalitutdup ⇒ *sqʷəl* ⇒ *dxʷatəbəd* ⇒ *səxʷləxəb* ⇒ *absčəčqsalí* ⇒ beaver den ⇒ *sləxíl* ⇒ river
(object place) (berry thicket) (wide lake) (prairie) (Mosquito Place) (Dawn)

Figure 2: *Order of location encountered on the trail to the land of the dead in the example discussed.*

¹⁰ All Lushootseed names for the locations along the trail are from Miller’s appendix of corrections for Waterman’s (1930) terms (Miller, 1988: 197-198).

Next, the journeyers came upon *sq'ʔəl*, a “famous place” according to Waterman, although he does not mention why (1930: 138). In this location the trail passed through a berry thicket full of berries. But these are not just ordinary berries: “the berries were hopping about in the size and shape of human babies” (Miller, 1992: 10) and “[i]f one tries to pick them, they fly away” (Waterman, 1930: 138). Often the journeyers would stop and try to pick these berries. Miller suggests that the shamans would try “to pluck a berry or two with their poles,” which was a difficult task, “and their clumsy antics created much humor for the audience” (1999b: 139). Both Waterman (1930) and Smith (n.d.) concur with Miller regarding the use of the poles, but Smith’s field notes suggest that only the shamans who had a female figure (Little Earth) would know how to accomplish the task (n.d.: MS268:5:2 no. 30).

The third location on the trail to the land of the dead passed through was *dxʷatəbəd*¹¹ — a wide lake. The travelers crossed the lake by laying their *təstəd* end to end to make a boat (Waterman, 1930: 139; cf. Miller, 1999b: 139). To aid in propelling themselves across the lake, one of the shamans who had a lake-dwelling guardian spirit, such as Otter¹², would call out for it (Miller, 1999b: 139).

On the far side of the lake was *səxʷəxʷab*¹³, a wide prairie full of game animals (Miller, 1999b: 139; Waterman, 1930: 139-140). Now the shamans’ poles become bows as they hunted (Miller, 1992: 11). In Dr. Bill’s¹⁴ account to Smith (n.d.: MS268:5:2 no.

¹¹ This is my adapted spelling from Miller’s corrections (see footnote 7).

¹² Following Miller (1988) when discussing animal guardian spirits, they will be capitalized while biological animal species will be uncapitalized: “Hence, Wolf, Bear, Loon, etc. refer to immortal or spirit forms of these species, not to zoological creatures” (Miller, 1988: xvi).

¹³ See footnote 8.

¹⁴ Miller discusses this account as being from Jerry Kanim (1988: 26-33) based on Pamela Amoss’s inventory of Smith’s field notes. When I viewed the copy of Smith’s field notes held at the British Columbia Provincial Archives I recorded that this information was from a man named Dr. Bill. Although

30) it was not a prairie on the far side of *dxʷʔatəbəd* but a forest with lots of deer. Often only a couple of travelers would hunt, but if a deer was taken the others would help skin and cut up the meat.

When the travelers finished hunting and continued on their way the trail led them to *absčəčqsalʔ*¹⁵, Mosquito Place. Here these insects were the size of birds and they attacked the travelers. They defended themselves against these insects with their poles for if one was ever stung the result was fatal (Miller, 1999b: 139). As Waterman states, “If a shaman is bitten by one of them, his whole body swells, and he dies” (1930: 140).

After making it past these insects the trail continues on until it reaches a swampy area. This area was Beaver Den¹⁶ where the travelers stop to hunt and their poles became spears (Miller, 1992: 11).

At this point the shamans have been traveling most of the night and as they move on to the seventh location — *sləxʔilʔ*¹⁷ — daylight approaches. Here the travelers go on to meet the Dawn where they must pause to “lift the daylight”: “The appearance of light added to the heaviness of their thick surroundings, so the curers had to pause to “lift the daylight” by passing their poles over their heads” (Miller, 1999b: 139). Dawn is fivefold¹⁸ in the southern part of Lushootseed territory, each with differing intensities and thus daylight had to be lifted five times so the travelers could safely pass beneath the light (Miller, 1992: 11). “It is like five people,” Waterman was told (1930: 141). Dr. Bill told Smith that the first two daylights are bad and heavy. Often a sick person would die before

both Dr. Bill and Jerry Kanim are Snoqualmie, and both my notes and Miller’s account in his book are similar, Dr. Bill and Jerry Kanim are not the same person (pers. comm., Miller, 2001).

¹⁵ See footnote 8.

¹⁶ No Lushootseed name was given by Waterman (1930: 140) for this location. Miller (1988: 197) provides the words *stəqəxʔ* and *dxʷʔastaqaxʔ* meaning beaver and beaver dam respectively in his appendix of corrections to Waterman’s terms (cf. Bates *et al.*, 1994: 2, 237).

¹⁷ See footnote 8.

morning as these bad daylights would take them away (Smith, n.d.: MS268:5:2 no. 30). Pamela Amoss points out that daylight is charged with supernatural power and that “[d]aylight, especially first light, is an essential ingredient in magic formulas” (1978a: 56). Amoss also suggests that a shaman who has recovered a soul would often wait until daybreak to return it to the person (1978a: 56). Now the travelers rest, for when it is day in the land of the living it is night in the land of the dead, and they will prepare so they could resume the journey when night fell (Miller, 1992: 11). “Sometimes,” Miller suggests, “the lead shaman, if he had great power, would take time to make a quick trip to the land of the dead to plan the final assault better” (1999b: 140).

When night fell the next day the journey resumed, and the travelers reached the final difficulty before the first land of the dead¹⁹. Here the trail leads through some woods to the banks of a river (Waterman, 1930: 141). This was a torrential river “with collapsing banks and on-rushing boulders” (Miller, 1999b: 140). The travelers always paused here to discuss how to cross the river and Waterman suggests that one of the travelers would always propose to move upstream to a spot that was called *qīqādəd*, jumping place (1930: 141-142). Although Waterman translates *qīqādəd* as “jumping place,” such a translation fails to emphasize the risk of this action that this place name connotes (see Bates *et al.*, 1994: 178). A plain cedar plank would be propped up at one end forming a ramp that would help the travelers as they used their poles to vault across the river (Miller, 1999b: 140). This was a very dangerous moment for the shamans, as they would be suspended in the air only by their guardian spirits and “[i]f his spirits were weak or another shaman held a lingering grudge, that shaman would lose his balance”

¹⁸ Five is “the sacred pattern number for southern Lushootseeds” (Miller, 1999b: 139).

¹⁹ The beliefs regarding multiple lands of the dead will be discussed in further detail shortly.

(Miller, 1999b: 140). Smith (1940: 60-61) discusses some instances where shamans would enter into a duel in which the shaman with the stronger abilities, or powers, would win. Smith suggests that shamans who had continual success in these duels were an advantage to their village: “Not only did [the shamans] lend [the village] prestige but they protected its members from the malignant efforts of outsiders” (Smith, 1940: 61). The inter-group/-village nature of these shamanic contests is reflected in Elmendorf’s finding that what he calls, “intercommunity malignant magic” served as a substitute of intergroup raiding (1960: 474). A shaman who had lost one of these duels had an opportunity for retribution at this point in the ceremony. If a shaman was to slip or fall at this juncture “he died within a year” (Miller, 1992: 11). Waterman suggests that if a traveler did fall the shaman would die instantaneously (1930: 142). Moreover, “[t]he slightest slip or misstep on the part of the [shaman] was interpreted to mean that his supernatural power had failed him” (Waterman, 1930: 142).

Now the travelers were near the land of the dead and the *q̄ilbid* was beached (Miller, 1992: 11-12). Most of the travelers would continue down the trail to the village where the dead people lived, while a few of them would remain behind turning the *q̄ilbid* around — by reversing the planks and figures — in preparation for departure (Miller, 1999b: 140). Sometimes, while following the trail to the village the travelers would encounter a ghost that was picking berries. “A ghost could be identified,” writes Miller, “because he or she walked by crossing and recrossing the feet” (1992: 12). Pretending they were ghosts, the travelers would query the ghost “for news and learned the quality and name of the newest occupant and where it dwelled” (Miller, 1999b: 140). This newest occupant was the spiritual aspect of the patient (Miller, 1999b: 140). When the

travelers knew where to find what they came for, they killed and buried the ghost. “This was possible,” explains Miller, “because there were at least two lands of the dead” (1992: 12; see also Sampson, 1972: 11). The inhabitants of the first land of the dead are those who are still remembered by the living and as this remembrance fades, the ghosts die again moving on to the second land of the dead (Miller, 1992: 12). This correspondence between remembrance by the living and which land of the dead a particular ghost inhabits is reflected in the belief that it was the more recent dead, and thus better remembered, who were more dangerous to the living (Smith, 1940: 97). Elmendorf suggests that the second land of the dead is ““on beyond” and not below the first land of the dead” (1960: 519). Thelma Adamson was told that when a ghost died in the first land of the dead they crossed a river on the far side of town where they were forgotten by the living. Adamson was also told, though, that those who had been dead for a long time went to the far end of the town and not across the river (in Miller, 1999a: 50). Thus, as ghosts moved from the first land of the dead to the second, the ghosts not only moved further away in distance but they also became more distant in memory. The second land of the dead was significant, according to Elmendorf, as it was from this land that ghosts would be reborn as newborn children in the land of the living (1960: 517). In addition, Miller notes that “there are also indications of even more remote lands of the dead, where they faded further into oblivion — somewhat like the half-life of a radioactive element” (1999b: 75). “The cycle, in theory, was endless,” states Miller, “either through rebirth or through increasingly remote abodes of unremembered dead” (1999b: 140).

With this new knowledge from ghosts questioned, the travelers formulated a plan about what they were going to do when they got to the village in the land of the dead.

One such strategy was to have one of the shamans' guardian spirit power appear as a game animal on the outskirts of the village (Miller, 1999b: 140). Upon seeing the animal, the ghosts would rush out to hunt it, leaving the village empty. The most powerful shaman would then steal into the village, acting like a ghost, and take back the patient's missing spirit (Miller, 1999b: 140). Collins suggests that sometimes the ghosts would keep the patient's spiritual aspect in a bag strung up in the house (1974: 201). Dr. Bill told Smith that when inside the house the shaman would look around checking for other spirits of people who are alive and who do not know that their spirit is gone yet (i.e., those people who have not gotten sick yet). If any of these latter spirits were found, these would also be brought back and returned to their owners. Also if the shaman sees anything else they would like to have, such as a shirt or money, they would also take it (Smith, n.d.: MS268:5:2 no. 30). Quietly rushing back towards the *q'ilbid* the other travelers would join in to help protect the traveler with the spirit (Miller, 1999b: 140).

Once they had boarded and set off back down the trail, one of the shamans would "throw his meanness" back at the village. This was done because if they had merely lured the spirit away the ghosts could still take it back: "Apparently, by successfully fighting for the lost spirit, shamans were able, in fairness, to keep it" (Miller, 1999b: 140-141). An impressive battle ensued:

In some towns, this battle between shamans and ghosts was enacted with long flaming splinters shot at the shamans by youngsters acting the part of the ghosts. ... Since the enactment took place at night, often inside a house, it was both dramatic and fraught with danger because of the hazard of fire in old wooden buildings. [Miller, 1992: 12]

"At this time," Miller states elsewhere, "the shower of fire arrows must have been dazzling, and the noise deafening" (1988: xviii). The travelers would rush home,

sometimes taking a shortcut with the Little Earths providing protection, to return the spirit (Miller, 1992: 12).

Upon returning to this world the shamans would be shaking with power (Miller, 1992: 12). Haeberlin writes, “After their return, the shamans “blocked the trail” so that the ghosts could not follow them into the land of the living” (1918: 256). But he confesses, “I do not now how this was done” (1918: 256). The shaman who led the journey would return the missing spirit to the patient by acting “as though he was pouring it into the head of the invalid” (Miller, 1999b: 141). Waterman states that the shaman who had brought back the patient’s missing spirit would begin shaking at this point in the ceremony (1930: 146). Miller found this shaking towards the end intriguing in light of the practice of shaking integral to the ceremonies of the Coast Salish Indian Shaker Church religious movement (Miller, 1988: 193). Amoss (1978b), in her discussion of the Indian Shaker Church, does note Waterman’s reporting of this shaking during the *sbəłtədaq* ceremony, but is uncertain if there is a direct connection between the two forms of shaking: “Whether or not this particular ceremony provided the model for the Shaker practice, the probable source of both the outward form and the conceptual content of Shaking was the old religion. Shaking was equivalent to ... the shaman’s trance” (Amoss, 1978b: 234; see also Amoss, 1990). Another aspect of the ceremony where the shaman shook was recorded among the Chehalis. Adamson recorded that in the process of making a diagnosis the shaman would shake while in a trance (in Miller, 1999a: 49). This practice of shaking during diagnosis is also seen in Shaker cures (Amoss, 1978b: 234). Signs that the patient was recovering would be heard: “Slowly at first, then with renewed vigor, the victim began to sing his or her power song” (Miller, 1999b: 141). Waterman

adds that the patient would also dance while singing (1930: 147). Contrary to these relatively immediate signs of recovery, George Dorsey suggests that it was not until four days after the return of the patient's spirit that the ceremony's outcome would be known: "At the end of the fourth day one of [the shamans] signified to the spectators and friends of the sick man that they had been successful" (1902: 237). Dorsey's account also runs contrary to most of the other descriptions discussed here in that he suggests that throughout this four day period the painted boards remained in place (1902: 237).

If the patient did not get up and start singing and dancing it signaled that the wrong spirit was brought back (Haeberlin, 1918: 256). Haeberlin suggests that in this situation "the shamans had to return the payment which they had received at the beginning of the ceremony" (1918: 256). As suggested above, the painted boards would only be used once, but, and *contra* Haeberlin, the only reason why the boards would be reused was in this situation of the wrong spirit being brought back: "Only in the most dire of circumstances could boards be reused for an immediate return to the land of the dead, always accompanied by special songs" (Miller, 1999b: 141). If the boards were to be reused they would be washed and repainted (Smith, n.d.: MS268:5:2 no. 30).

The ceremony ended with the distribution of all the things that were brought back during the ceremony, including the return of other spirits that the shamans had found in the village of the dead, and any information that the travelers learned about future conditions was told to all those listening (Miller, 1992: 12). Sam Wilson, a Suquamish man, told Smith (n.d.: MS268:5:4 no. 6) the story about how one time the blood of one of the chiefs of the dead, who had been killed, was brought back. When the shamans were distributing what was brought back, they asked which woman wanted the blood. James

Seattle told them to give it to his wife, so the shamans put it in her. The shamans told her that if she had a baby it would be very small and soft. It would have no bones because they only blood put into her. Later she gave birth to a small, double-jointed child they named Moses (Smith, n.d.: MS268:5:4 no. 6; see also Elmendorf, 1993: 234-235). This child was a grandson of one of the most famous Coast Salish chiefs: Chief *siʔaʔ* (commonly anglicized as Seattle) (Miller, 1988: 35; see Hilbert, 1986 for a discussion of Chief Seattle).

The *sbəltədaq* Ceremony as Being-In-The-World

But how does the *sbəltədaq* ceremony reflect and/or reinforce the manner in which the practicing groups perceive the world? In the context of this thesis the inter-group, and even intra-group, variations, which Miller also discusses (e.g. 1999b), are of importance. In this section I will discuss five general topics in the same order as discussed in the preceding section: seasonality; paraphernalia; the trail; the land of the dead; and audience participation, in the context of how the ceremony is involved in the perception of the world. These variations in the ceremony are important in the context of this thesis. Not only does the ceremony reflect and/or reinforce a particular mode of engagement in the world, but through the ceremony's healing function the particular mode of engagement incorporates the participants. As Tim Ingold writes,

[K]nowing is not a matter of being in possession of information handed down from the past, but is rather indistinguishable from the life-activity of the organism-person in an environment which has itself been, and continues to be, fashioned through the activities of predecessors and contemporaries. It follows that knowledge is perpetually generated, rather than applied, in practice. [1997c: 2]

Ingold and other authors writing from a similar perspective (*e.g.*, Anderson, 2000; Feit, 1994a, 1994b; Scott, 1989, 1996) generally focus on rituals and practices associated with native subsistence practices. In this section I will attempt to show how a study of a medical practice can serve a similar purpose. I argue that by conceiving of the *sbəłtədaq* ceremony as a mode of LTK, we can then consider the ceremony as a local practice that generates and sustains the knowledges of the various Coast Salish groups that performed the ceremony.

Seasonality

The *sbəłtədaq* ceremony was performed only during winter evenings. This was because “the seasons and also the times of the day in the land of the dead are exactly the opposite to what they are in this world,” thus, winter is “the only time of the year when the trail to the ghost-land is at all passable” (Haeberlin, 1918: 252; see also Smith, n.d.: MS268:5:4 no. 6). Not only were the seasons and time opposite in the land of the dead, but Collins suggests that the language spoken by the ghosts was the opposite: “The language of the ghosts was modeled on that of the living but was backwards, the sounds of each word being reversed” (1974: 232). Furthermore, “our high tide was their low one, and objects broken here were whole there” (Miller, 1999b: 136). This opposite time was also why shamans stopped to “lift the daylight” for as dawn approached in the land of the living, night was falling in the land of the dead (*e.g.* Miller, 1992: 11).

Seasons may have had more to do with the ceremony than just with reference to how passable the trail was. Smith discusses two types of soul²⁰ loss, based on seasons, that require a shamanic cure: 1) “the shaman cure necessary to return to the body the soul which had been lost”; and, 2) “that which had gone to the land of the dead” (Smith, 1940: 96). The difference between the two was “a matter mainly of seasonal variation,” as the simple shaman cures were as common in summer as in winter (Smith, 1940: 96-97). Dorsey was told that even the spirit of people who “died during the summer did not go at once to this underworld, but wandered back and forth on the earth until winter was well advanced” (1902: 236). It appears from Dorsey’s suggestion that the spirits of the recently dead were hindered, much like the shamans, by the impassability of the trail to the land of the dead during summer in the land of the living. Noting Haeberlin’s (1918) explanation for the timing of the ceremony, Smith found that her data suggested another possible explanation: “The explanation for “winter ceremonies” given by Puyallup-Nisqually informants consistently involved only the [seasonal cycle], which broke the village unit into fragments during the summer months and reestablished [the village] during the winter” (Smith, 1940: 97). But it was not only the living that gathered at the villages in winter, “the dead [also] returned and were particularly active around the village at that time. Unfortunately, their activity consisted in taking, or attaching to themselves, whatever clothes, possessions and souls of their relatives they could get at” (Smith, 1940: 97). The ghosts did not take these things as punishment, rather, they took them because they retain their human desires and “are tormented mainly by two things in the afterlife, hunger and loneliness. Furthermore, they miss their possessions” (Amoss,

²⁰ “Soul” is used by Smith (1940) but it is synonymous with what I have been calling “spiritual aspects” or “spirit.” In Lushootseed, the word for “soul” is *səliʔ*, which also has been translated as “life” (Bates *et al.*,

1978a: 73). This loneliness on the part of the ghosts may have resulted in their stealing the spirits of their loved ones so that they would have company in the land of the dead (Amoss, 1978a: 75-76; *cf.* Collins, 1974: 232). Excessive grieving by the living would also entice the recently departed to come back for the griever's spirit (Collins, 1974: 233).

The difference between the two types of soul loss was more than just a difference in seasons, for "the *lost* soul was returned to the body by a simple shaman curing ceremony, but the soul *stolen by the dead* could be recaptured only by the elaborate [*sbəltədaq*] ceremony" (Smith, 1940: 96). This difference had a geographical component to it: "The area in which a soul could be lost was strictly defined by the earthly wanderings of the patient's body. But the dead wandered the world and could carry the soul far beyond one locality. The journey for the latter was, consequently, very long" (Smith, 1940: 96). Thus, according to Smith, the *sbəltədaq* ceremony was performed not only because of a seasonally particular form of soul loss, but it was also performed because this soul loss involved a larger geographical context. Dorsey was also told that in summer the spirit that has been lost does not desire to go to the land of the dead. Rather, the spirit travels around in this world. But when it is winter in this world, the land of the dead is supposed to be quite appealing (Dorsey, 1902: 235). The fact that a lost spirit would wait until it was winter in the land of the living to go to the land of the dead reflects the notion that only in winter would the trail to the land of the dead be clear enough to travel along (Haeberlin, 1918: 252). Thus, a spirit that was lost during the summer could not then go to the land of the dead, nor could ghosts then travel to the land of the living. Since the trail was blocked the lost spirit could only go so far and, as Smith

suggests above, the places a lost spirit would go reflected where the patient traveled to in this world (1940: 96). The search for a lost spirit in summer then followed the patient's travels and experiences in the world of the living. Furthermore, in summer ghosts were less active in this world, possibly because of the blocked trail, so the possibility of having a ghost steal a spirit would have been minimized. Thus, we see in the distinction of seasonally particular forms of spirit loss a reflection of the patient's life and experiences (in the summer form) and a reflection and reinforcement of the Coast Salish conception of ghosts and the land of the dead.

Paraphernalia

The painted boards and the Little Earths are important in the context of this discussion. The boards varied in more than just the painting of the shaman's guardian spirit power. Although Wingert suggests, in the earlier discussion of the boards, "The shapes of all of the boards now extant are practically identical" (1949: 79), his statement is based on only the examples in various museum collections, and may not be supported in the ethnographic data (*e.g.*, Haeberlin, 1918; Waterman, 1930). The general overall form of the boards does appear to be similar, with the exception of the top section. As Miller states, "Every drainage had its own style of plank. For example, the Snohomish cut out the snout because they traced descent from a legendary cetacean" (1992: 9; see also Haeberlin, 1918: 253; Waterman, 1930: 295)²¹. Miller also suggests elsewhere that each board was "shaped to evoke the ancestor of the riverine community" which provided a safeguard to the shaman during this hazardous journey through the harnessing

of this ancestor's power (1988: 94). Smith attributes these differences in the top of the boards to differences in *sbəłtədaq* power and provides five variations. Smith's five variations do not include the snout-like form that has been attributed by some authors to the Duwamish, Snohomish, and Snoqualmie (Smith, n.d.: MS2687:5:4 no. 7; *cf.* Haeberlin, 1918; Waterman, 1930; Wingert, 1949). Contrary to Smith though, it appears that the form of the board was reflective of a group's mythology. For as Waterman's data suggested a connection between board shape and mythology: "My own information, however, is that the *form* of the plank represents a certain mythical monster which drew people from a distance into its maw by sucking its breath" (1930: 298; *cf.* Miller, 1988: 17). The relation of board form to different groups associated with particular drainage areas²² appears to be supported by the majority of the authors. Smith's suggestion seems out of place for the reason that the image painted on the middle section represented the shaman's guardian spirit power that permitted such a journey (e.g. Miller, 1992: 9). This is also suggested to be the case by another one of Smith's informants, Dr. Bill (Smith, n.d.: MS268:5:2 no. 30). The apparent contradiction in Smith's field notes (n.d.) could be a result of the opinions of different informants from different groups. Regardless, as stated, the majority of authors suggest the variation is due to drainage affiliation.

This notion of drainage system affiliation is important, for Smith suggests that it is interdigitated with "their major concept of social unity" (1940: 6). This major unity

²¹ Although both Haeberlin and Waterman suggest a different form for the Snohomish.

²² Although the Puget Sound region is one large watershed, "drainage areas/systems" is used here to refer to drainage divisions within the Puget Sound watershed.

was the village, which Smith notes “was fundamental to the social structure” (1940: 6).²³

Importantly, Smith suggests,

A particular village site and the drainage connected with it bore the same name. The people called themselves by the name of the village site plus a suffix meaning “people of”. When they spoke of themselves in relation to other peoples of the area they might use the term for the larger drainage of which their stream was a part, plus the same suffix. [1940: 6]²⁴

The suffix which means “people of”, is *-abs̓* (Bates *et al.*, 1994: 25, 41). For example:

dx̓d̥wʔabs̓, the Lushootseed word that has been anglicized as “Duwamish,” literally means “the people inside the bay” (Bates *et al.*, 1994: 80). It refers to the people’s former location on Elliot Bay (which is now Seattle). Similarly, *spuyaləpabs̓*, anglicized as “Puyallup,” literally means “the people of the bend,” who were so named because the river that these people lived on is full of bends (Bates *et al.*, 1994: 165). *ssq̓aliʔabs̓*, anglicized as “Nisqually,” refers to the grass or hay that grows where these people lived (*sq̓iʔq̓aliʔ* translates as hay or grass) (Bates *et al.*, 1994: 188). These examples reflect Waterman’s finding that Lushootseed Coast Salish place names are mainly descriptive (1922: 185; see also Smith, 1941: 199; *cf.* Suttles, 1987b; Suttles and Lane, 1990: 485). Smith also suggests elsewhere that beyond the village grouping no other groupings were named: “With the exception of the village, which constituted the primary social unit and which was tied terminologically and in fact to its location, no other sociologically significant group was named” (1941: 199). Thus the association of the painted boards with villages, *qua* drainage system, can be viewed as an intergroup marker of identity.

For, as Haeberlin points out,

²³ Wayne Suttles and Barbara Lane (1990: 493) suggest that the village was the most general residential grouping in Southern Coast Salish social organization.

Since in one tribe there were never as many as eight shamans who had the [*sbəłtədaq*] guardian-spirit, it was invariably necessary to hire such shamans from neighboring tribes in addition to those in the tribe of the patient. Thus the ceremony was bound to be an intertribal affair. [1918: 251]²⁵

But not every village group could cooperate with every other group because both the trail to the land of the dead, and the location of the land of the dead, varied for each group (Haeberlin, 1918: 251). For example, multiple authors (Haeberlin, 1918: 251; Miller with Snyder, 1999: 154; Smith, n.d.: MS268:5:4 no. 6) suggest that the Suquamish and the Duwamish could perform the ceremony together,²⁶ but neither could participate when the Snohomish, Snoqualmie or Skokomish²⁷ put on the ceremony (Haeberlin, 1918: 251). Henry Allen did tell Elmendorf that once when a Skokomish man's spirit was in the land of the dead, he had Duwamish doctors work on him. Duwamish doctors worked on the sick man as his family figured that it was a Skokomish shaman who had sent the man's spirit there (Elmendorf, 1993: 224-226). One reason why the Suquamish and the Duwamish were able to perform the ceremony together may have been due to the strong and close relations between the two groups — an issue that will be explored later.

Another way in which the *sbəłtədaq* ceremony reinforced and reflected an engagement with the world was in the construction and use of a *qilbid* to travel to the land of the dead. In the accounts of the ceremony that mention the use of a *qilbid*

²⁴ Waterman has a similar discussion to Smith's in his recently published manuscript on place names in the Puget Sound region (in Hilbert *et al.*, 2001: 14-16).

²⁵ Haeberlin's use of "tribe" here is analogous to Smith's association of villages with drainages, which I have been referring to as "groups".

²⁶ It also appears that the Twana could participate in the Duwamish version of the ceremony (see Elmendorf, 1993: 234).

²⁷ Although Haeberlin suggests that the Skokomish could perform the ceremony with the Snohomish and the Snoqualmie this may be incorrect. Miller suggests that Haeberlin may have misinterpreted, or meant, Skykomish (1988: 7). Miller's suggestion is supported by Elmendorf's data on the ceremony, as both of Elmendorf's main informants (Frank and Henry Allen) were Skokomish Twana (a subdivision of the Twana and present day reservation) and as the previous footnote suggests, it appears that the Twana could participate in the Duwamish ceremony (Elmendorf, 1993: xxix, 234).

(Elmendorf, 1993; Miller with Snyder, 1999; Smith, n.d.: MS268:5:2 no. 30; Waterman, 1930) often the *q̄ilbid* was signified by the placement of the painted boards (see figure 1). In the account of the ceremony recorded by Warren Snyder, behaviour of the shamans' while in the *q̄ilbid* provides a public display of how one should act in a real canoe (in Miller with Snyder, 1999). For example, when the shamans were dancing inside the *q̄ilbid* they kept their feet on the ground. The shamans did this because if they were to lift their feet up they would tip the *q̄ilbid* (Miller with Snyder, 1999: 154). On the return trip the Suquamish shamans would shake the boards forwards and backwards to go faster. The shamans did not shake the boards side to side, for again this would tip the *q̄ilbid* (Miller with Snyder, 1999: 155). These actions, or precautions, reflect behaviours that one should be following while in a real canoe. Thus not only would the boards serve as an intergroup marker of identity, the boards, through their role in the *q̄ilbid*, would reflect behaviours applicable in the land of the living.

The carved human effigies, or Little Earths, indicate different associations with the lived world than those represented by the painted boards. The Little Earths are important, not only because they provided the shaman with *sbəłtədaq* power, but also because they “were another order of beings who “owned” the land” (Miller, 1999b: 62). Moreover, *swatix"təd* — the non-reduplicated form of *swaw'tix"təd*, Little Earths — translates as land, country, place, region or world (Bates *et al.*, 1994: 245; see also Smith, 1940: 132). The Little Earths were most often associated with “thickly grown, damp gullies or creek beds overgrown with vegetation,” but Smith also points out that “each and every locality was said to have dwarfs connected with it” (1940: 131-132).

Elmendorf has also suggested that the Little Earths “could influence the movements of

fish and game animals and thus affect the hunting or fishing luck of persons toward whom they were favorably or unfavorably inclined” (1960: 532). Thus the Little Earths were inextricably connected to the world/the land, aiding not only in healing but in many other activities as well.

These beings were also used by shamans for other cures (Miller, 1999b: 133), but it is the role played by the Little Earths in the *sbəłtədaq* ceremony that is of importance for this discussion. It was not actually the shamans who journeyed to the land of the dead; instead it was believed that the Little Earths made the journey while the shamans merely acted their journey out for the spectators (Miller, 1999b: 136). Miller suggests that the relationship between the Little Earths and the world was key in conferring the ability, or power, of a shaman to journey to the land of the dead: “A shaman befriended by a Little Earth had the ability to go to the land of the dead and return *because the dwarf was so closely tied to the land that he or she also held the shaman tightly to the everyday world*” (1999b: 62-63; emphasis added). Miller also suggests that there was a recursive link between the effigy and the dark semi-circle at the base of the painted boards (1988: 94). In short, I propose that the Little Earths can be viewed as an environmental mediation/intercession between life and health, on the one hand, and illness and death on the other, through their role in the *sbəłtədaq* ceremony.

Collins suggests that illness and death are more intimately linked in the Coast Salish nosology than in the biomedical nosology, in that illness diagnosed by a shaman is conceived not as a temporary state but as a prelude to death,

from which people may be expected to recover. ... In Western society, the source of the illness is not necessarily fatal. To the Skagit the source bringing about the illness progresses inevitably to death unless intervention is made. [Collins, 1974: 206]

Thus, when the diagnosing shaman determined that the patient's spirit has gone to the land of the dead there was a sense of urgency — even the Little Earths run to the house when they hear the shamans singing, arriving out of breath (Miller, 1999b: 137; Smith, n.d.: MS268:5:2 no. 30). The Little Earths, as suggested above, represent a spiritual relationship between the earth and humans, which includes not only health and healing (Little Earths can also cause illness) but also hunting and gathering (Smith, 1940: 131-133). As Elmendorf suggests above, the Little Earths “could influence the movements of fish and game animals and thus affect the hunting or fishing luck of persons toward whom they were favorably or unfavorably inclined” (1960: 532). For it was the Little Earths that owned the land, and any misuse of the products of the land, especially of food, displeased them (Smith, 1940: 132; *cf.* Collins, 1952 regarding the relationship between Coast Salish people and game). A person even had to ask the Little Earths for permission to take a drink of water when alone (Miller, 1999a: 47). Thus not only were the Little Earths important for shamans, the Little Earths were also of concern for everyone else as they engaged the world.

The Trail and Places Encountered

In the context of this thesis, the trail, and the various places along it, exemplify the interaction and connection between medical practices and the world. The entire trip to the land of the dead reflected the group's local landscape in that, for example, the locations encountered along the way were specified to such local conditions (Miller, 1988: xviii), the direction and terrain of the trail depended on the location of the house that the ceremony was being performed in. Miller also suggests that the order of events in

the ceremony was also influenced by the personalities and experiences of the shamans and the other participants (1988: 91). Furthermore, Miller also suggests, regarding the specification of the ceremony to the local geographical context, “A sense of place was so profound that every ceremony enactment was tailored specifically to the locale and people involved” (1999b: 136). Thus, although the *sbəltədaq* ceremony was practiced throughout the Puget Sound region, each performance reflected the particular geographical and experiential contexts in which the ceremony was performed.

The specification of the ceremony was so explicit that Haeberlin argues that although there was no specialized ceremonial house, only houses that were oriented east-west would be used. The reason given by Haeberlin for this was that it was believed that the trail to the land of the dead went west (1918: 252). On the other hand, Smith suggests that the length of a house always ran parallel to the creek or river that the house was situated next to (1940: 280; see also Suttles, 1954: 61). This suggestion has implications for Haeberlin’s argument in that it either invalidates Haeberlin’s assertion or it excludes certain villages, one built around a point in a river that is not oriented east-west, from performing the ceremony. Or, it may be that the westerly direction of the trail to the land of the dead refers to a ceremonial direction, rather than a cardinal direction much as the “east door” does in Catholic churches. This possibility may explain the lack of agreement that I found in my investigation of the various accounts of the ceremony regarding where the land of the dead lies.

The use of any house that was large enough to hold the ceremony, rather than a specialized building, contrasts with biomedical settings for healing. As Kaja Finkler suggests, the biomedical model of healing “conceives of the person as an autonomous

unit, independent of and isolated from other individuals and from social and cultural contexts” (1998: 121; see also Foucault, 1991). The biomedical healing encounter thus removes the patient from all of their familial, social and cultural contexts. In the *sbəltədaq* ceremony, as in most Coast Salish healing ceremonies, it was most often the patient’s home that was used, filled with friends and relatives to aid in the ceremony. Thus the patient remained in the familial, social and cultural milieu, for these contexts, unlike in biomedicine, are essential components of a successful cure.

The orientation of the house affects the initial procession of the shamans, and subsequent activities. If the procession enters through the downriver door, the bowman, who is the most powerful shaman of the groups, enters last; if the procession goes through the upriver door²⁸ then the bowman enters first. According to Smith’s informant Dr. Bill the determination of which door the procession entered depended on the location in the woods in which the painted boards were made (Smith, n.d.: MS268:5:2 no. 30).

One possible reason for variation in the order of the shamans’ procession was the belief that the trail to the land of the dead was downriver in direction (Elmendorf, 1960: 518). This downriver direction of the trail may be the reason why Haeberlin argues that the house must be oriented east-west and that the land of the dead was in the west. The groups Haeberlin got his data from resided on the eastern side of the Puget Sound. Thus, downriver was in a westerly direction. It is conceivable that, if the trail does indeed go downriver, that the trail could point in a northerly direction for groups at the southern limits of the Puget Sound. Although Elmendorf does not explicitly mention a direction for the trail, the Twana people with whom he worked, as they lived on the western side of

²⁸ The houses used in winter by the Coast Salish often had two entrances at opposite ends of the house (Elmendorf, 1960: 162; Smith, 1940: 280).

the Puget Sound they might have had a trail that lies to the east. Haeberlin was also told that the positioning of the shamans was influenced by the sun's path. Haeberlin noted that there was some sort of association between the sun and the journey, but "[s]uch associations are naturally hard to get at" (1918: 257).

The orientation of the house also affected where people could sit. No one would sit at the bow, or downriver, end of the *qilbid* "because this location was the most vulnerable and dangerous" (Miller, 1988: 34; Smith, n.d.: MS268:5:4 no. 6). Perhaps this is why the most powerful shaman was the bowman. Interestingly, in Haeberlin's account of questing for the *sbəltədaq* power he writes that the power travels around in a canoe. It is the bowman in this canoe that represents the *sbəltədaq* power and the individual, standing on the shore, who is questing for the power must rush through the water and grab the bowman to attain the power to go to the land of the dead (Haeberlin, 1918: 250).

The geographic location of the house also had implications for the ceremony, especially with regards to the trail (Smith, n.d.: MS268:5:2 no. 30). The location of the house, in the most general sense, would affect the direction and terrain of the trail through which village the ceremony was performed — thereby reflecting intergroup and geographical differences in the ceremony. As Miller suggests, "Direction and terrain depended on the location of the house where the ceremony was being held" (1988: xviii). Which group was performing the ceremony also affected the terrain of the trail, as Henry Allen told Elmendorf: "Once some Twana people from here went on [*sbəltədaq*] with the Duwamish. The Duwamish doctors took them along. ... Those Twana people said the way they went was a lot harder and very different from the Twana trail" (Elmendorf, 1993: 234). Regarding these different trails, Miller points out, "When different tribes said

that there were various routes and destinations, they seem to have had in mind their different drainage systems” (1988: 98).

But the trail was not a water route. Rather, it was a trail or a footpath, for the shamans took the same trail that the soul would walk along (Miller, 1999a: 49). It appears, though, that there was another opposition in addition to the ones mentioned earlier. This opposition was between land and water which may also help explain Waterman’s previously mentioned confusion regarding why the shamans would have to make a boat when he thought that the shamans were already in a boat (1930: 139). I suggest this not only because of Miller’s statement above about the various routes and destinations,²⁹ but also because, for example, Smith was told that all the bad places in the river got described, such as Snoqualmie Falls or a big rock with an eddy below it (n.d.: MS268:5:2 no. 30). Although the shamans took the same trail as the soul walked along (Miller, 1999a: 49), this does not necessarily mean that the shamans also walked, as some ceremonies utilized a *qilbid*. In the Twana version of the ceremony that Elmendorf recorded in his earlier work, however, the journey was carried out by the shamans mainly on foot (1935: 44).

Although it appears that often the *qilbid* was paddled, thereby suggesting a canoe, a *qilbid* does not necessarily connote a canoe, as discussed earlier. “Thus,” writes Miller, “the [*qilbid*] and passengers were not limited only to water travel; they could move through any other medium as well, whether air or earth” (1988: 84). Elmendorf also suggests that the *qilbid* had the power to make land into water (1935: 37). Furthermore,

²⁹ Although just because the people had in mind different drainage systems does not necessarily mean the water course. As Smith suggests, “Canoe travel naturally followed water courses but, more than that, trails likewise could best be maintained on beaches and along the shores of streams where the annual floods swept a clear path” (1940: 2).

paddling was not the only means of propelling the *qilbid*. For example, in the Suquamish version of the ceremony, as recorded by Snyder, the shamans would shake the boards to propel the *qilbid* more quickly (in Miller with Snyder, 1999: 155). Miller also points out that a common feature of all the accounts of the ceremony is the specification of at least two rivers and that all accounts either start on a river, and cross one river, or cross two rivers while following land trails (1988: 86). It is based on the above evidence that I put forth the suggestion that there is a reversal of land and water in the land of the dead. Any evidence that would appear to contradict my suggestion may reflect the group's local geographical context.

Waterman states that, "The trail leading to [the land of the dead] is often described, and on the way thither one passes a number of well-known spots" (1930: 134). The specification of the trail to the local landscape was also reflected in the portrayal of the journey by the shamans. Smith suggests that the portrayal "differed somewhat for each group which performed the ceremony or for each occasion" (1940: 99). The change with respect to the occasion is significant because, as Waterman states, "A person watching the performance can tell at a glance, by the behavior of the [shamans], just which stage of this well-known journey they have reached" (1930: 135).

The performative aspect is also significant in the healing context. Henry Allen, one of Elmendorf's informants, suggested that the performative aspect of the ceremony was similar to the "bedside manner" of biomedical doctors:

Now while all this is going on, the [*sbəłtədaq*] people are acting it out up here in this world. They go through all the motions of the whole trip up here in the big house where they hold the ceremony. One of the audience acts as a ghost when they catch one, and the doctors coach him to give answers that will make the patients and their relatives feel good. ... So the doctors want those relatives to

believe the [ceremony] will do the sick people good. They have the same idea as a white man's doctor. All acting is for the patients and their relatives in this world. [Elmendorf, 1993: 235]

Arthur Kleinman (1980: 286ff.) in his discussion of biomedical practitioner-patient interactions in Taiwan noted the high number of injections given to patients. Over 3/4 of the clinical cases he observed included an injection of some kind. Although there was a strong financial motive for this high rate of injections, Kleinman suggests a stronger motivation: “giving an injection is giving the patient the message that you are offering him the best treatment you possess” (1980: 287). But such injections were not necessarily the best treatment that the practitioner had access to. Rather, Kleinman was told that this practice was due to the realities of health care in Taiwan: “Since referral by satisfied patients is how most patients in Taiwan get to doctors, it is not surprising that doctors fear going against such expectations” (Kleinman, 1980: 288). Thus both the Coast Salish doctor and the biomedical doctor, as in the Taiwanese example above, provide the patient and families with medical proofs that are consistent with their expectations (Young, 1976: 9). The questioning of the ghost by the shamans, in a way, can be viewed as a labeling process: questions to the ghost by the shamans are concerned with which spiritual aspect of the patient was taken. If we expand the notion of “disease,” as discussed in an earlier chapter, beyond its narrow biological definition (see Kleinman, 1988: 5-6) and consider the process of labeling instead, a key difference between the Coast Salish shaman and the biomedical doctor rests with their background cultural assumptions — an issue that will be discussed in further detail in the next chapter.

It is my contention that the specification of the trails and the stops along the way reifies and reinforces a particular mode of perceiving the world. This role of the ceremony in perception has also been suggested for biomedicine:

It is in the constitution of such [lived] experience that medicine assumes a privileged role, in our society as in any other. For healing plays upon the relationship between physical and social being, tapping that primary source of symbolic media, *the interface between self and world*. [Comaroff, 1982: 63; emphasis added]

I am concerned with the role of medical practices in the constitution of lived experience. Claude Lévi-Strauss (1998 [1963]) suggests, that healing practices give meaning to an individual's experience of ill-health through the lens of the group's cultural axioms. The trail to the land of the dead reflected the local geography, and the various stops along the way reinforced a mode of perceiving the world. The stops could also have other important implications in this world.

Waterman translates, *sq̄lalitutdup*, the first location that the travelers encounter, as meaning “ceremonial-object place” (1930: 137). Miller suggests that “[t]echnological relations with the environment were at the forefront of the rite,” (1999b: 143) and the various objects found in the area provide an explicit example of these relations. Not only were the trail and the conditions group-specific in the ceremony, so too were the materials and, as will be discussed later, so too were the other things collected (Miller, 1999b: 143, 1988: xviii). *sq̄lalitutdup* translates better as guardian spirit (*sq̄lalitut*) and distribution or expanse (*-dup*) (Bates *et al.*, 1994: 85, 175; Miller, 1988: 197). The songs that each object was singing at this location had more than ceremonial implications, Miller suggests that learning the songs “would help people ... use tools more efficiently” (1999b: 137). These songs aid in tasks because “[a]rtifacts themselves represented the

full cooperation of natural products, human resourcefulness, and spiritual inspiration” (Miller, 1992: 10, 1988: 87). Artifacts embody this cooperation due to the belief that “[a]ll success involved a spirit and human bond Through it, a human could fulfill any task, career, or undertaking” (Miller, 1999b: 22). Elmendorf suggests that shamanic healing and other activities, including, in his example, canoe making, were considered as concordant situations:

In both cases the operator directed his actions according to a well-defined technique to bring about a definite result: the curing of a sick person or the shaping of a finished canoe. And in neither case was the technique alone believed to be sufficient to attain the objective. Without a relationship to a supernatural being and the special kind of power derived therefrom neither operator would have the skill or ability to bring about any result at all. [1960: 481]

This relationship extends beyond the use of tools or in manufacturing: “In this culture *all* human success and failure, skill and mediocrity, received their explanation in terms of personal relations or lack of relations with supernatural beings” (Elmendorf, 1960: 481; emphasis added). Miller suggests that because *sq̄lalitutdup* was first the first location encountered along the trail it reinforced “that it was the spiritual aspects of existence that were the most important, a logical beginning place for any such journey, and for life in general” (1999b: 138). In short, guardian spirits permeated all aspects of an individual’s life and this first location, in name and description, reinforced this notion. For as suggested above, guardian spirit power was central for any individual to achieve any level of success in life.

Miller suggests that the next location (noted as *sq̄ʷəl* by Waterman) served as a reminder of the unity of all life in the world: “Since everything was believed to have an essential human form under the cloak of its species or appearance, this visit was a

reminder of the common humanity of all life” (Miller, 1999b: 139). For example, Collins writes that “in Skagit thought, animals were formerly not only present in human form but even today do not all live the year around in animal guise” (1952: 354). Even the essential form of the guardian spirits was like human people. They would cover themselves with their earthly representations when they left their homes:

According to Lushootseed mythology, all of these immortals were and are “persons” who shared qualities that made them akin to humans. All of them were specifically said to have human or humanoid characteristics, disguised when outside their abodes by the covering of their species or natural form. [Miller, 1999b: 22]

This perspective regarding the guardian spirits led Miller to suggest that the best way to understand the guardian spirit system is through A. Irving Hallowell’s (1960) notion of “other-than-human persons” (Miller, 1999b: 10; see also Ingold, 2000b for a further discussion of Hallowell’s notion). Another similarity between Coast Salish guardian spirits and the notion of other-than-human persons is in both their roles in helping a person fulfill any task, career or undertaking. Hallowell writes that for an Ojibway person to achieve the central goal of life, it

cannot be achieved without the help and cooperation of both human and other-than-human persons, in addition to one’s own personal efforts. ... Every special aptitude — all a man’s subsequent success, and the explanation of many of his failures, hinged upon the aid ... of other-than-human persons. [Hallowell, 1976: 407]

Furthermore, Hallowell (1976: 415-416) suggests that it is the other-than-human persons that confer the ability to cure onto individuals — similar to what happens with Coast Salish healers and guardian spirits (e.g. Elmendorf, 1960: 481).

This location, *sq’wəl*, could also have implications in the world of the living. As mentioned earlier, some of the shamans would try to catch some of the berries. If

successful (and success was in no way guaranteed in here or any of the other location) one or two berries would be caught and then placed in a cedar basket that was on the back of the Little Earth effigies (Smith, n.d.: MS268:5:2 no. 30). The catching of one of these berries reflected another Coast Salish belief: “For the most powerful individuals, their personal actions could affect the world” (Miller, 1999b: 146). For upon their return the shamans would throw the berries in an area where they will grow, ensuring a bountiful harvest next year (Smith, n.d.: MS268:5:2 no. 30, MS268:5:4 no. 6; Miller, 1999b: 139). Furthermore, the specification of the ceremony was extended to what was collected. Miller suggests that the resources that were familiar to the group were collected along the way: “After that, stops included bouts of hunting, fishing, berrying, and other resource collecting familiar to the community” (1988: xvii).

dxʷnatəbəd, the wide lake, was also important with regards to guardian spirits. “Since deep lakes were and are the abodes of powerful spirits,” states Miller, “this place was a particularly important source of power” (1999b: 139).³⁰ Further reinforcing the association of lakes and powerful spirits Waterman suggests, “If anyone has a “power” which is weak ... he is likely to be lost [at this location]” (1930: 139). As Dorsey recounts, “He admitted that the desire of his own spirit and those of his fellow-doctors

³⁰ Adamson recorded the Upper Chehalis story of “The Dangerous Lake Being” (told to Adamson by Mary Heck; in Adamson, 1934: 124-126). This story is about five brothers (five being the sacred number for southern Lushootseed people) and what as a lake in the time of the story, which became a little section of prairie. The dangerous being had eaten the four older brothers by enticing them out into the lake by putting an elk in the lake. The youngest brother did not know what had happened to his other brothers until he had a dream. In his dream he was told what had happened and how to get his brothers back. The brother woke up, went to the lake as he was instructed by his dream, dried up the lake by putting boiling rocks in to it, boiling the water away, and saw the being. He killed and opened up the being and saw his brothers inside, but they were starting to decay; so he left the lake dry. John Fornsby, a Skagit man, told Collins about his Loon guardian spirit, which confers curing power, and, according to Fornsby, “used to stay in the lake back of Mount Vernon” (Collins, 1949: 327; cf. Smith, 1940: 68; Jenness, 1955: 53). Jackson Harvey, another Skagit man, also told Collins about how his son’s spirit quest took him to a house at the bottom of a lake (Collins, 1974: 177; see also Elmendorf, 1993: 167-183).

[*sic.*] to remain in the under-world was very great; but he explained that a man, to be a doctor, must possess an unusually strong will” (1902: 237).

Water is also involved in some other forms of shamanic healing. In the pulling style of curing,³¹ as witnessed by Michael and Della Kew, the Kews were told by the practicing shaman about the bowl of water he was using in the curing, “You know I have great faith in this water. It can do a lot. It can work miracles. You know, everything needs water — the plants, and all living things, they all need it” (in Kew and Kew, 1981: 33). Again we see the intermeshing of the spiritual world, *qua* the shamanic healing, humans and the earth. Henry Allen told Elmendorf about how people who had been shot by a shaman — a type of spirit intrusion — were cured by sucking out whatever was shot into the patient. When the shaman removed the object or power it would then be dunked in water (Elmendorf, 1993: 217-219). No reason is given for why this was done but it may possibly be connected to the role of bathing to purify oneself while questing for a guardian spirit (see Collins, 1974: 175-177).

Miller also suggests that “lakes and marshes provided a wide variety of foods, which were also being celebrated at this stop,” but Miller does not say how these foods were celebrated (1999b: 139). In my research I did not find any similar suggestions, nor did I find any accounts documenting that any of those foods were collected (which does not necessarily mean they were not). These foods may have been celebrated through the appearance of a lake in the ceremony, in which the lake served as a reminder of not only the spirit power of bodies of water but also of the material benefits derived from bodies of water.

³¹ See also Smith, 1940: 79-82 for a discussion of this style of curing.

The next location visited was *səx"ləḡab*, the wide prairie. Prairies were not only important for game animals, but they were important for the root crops (Miller, 1988: 88-89). Although there is no mention of the collection of food crops here in the literature, as was the case with the location *dx"latəbəd*, it must have been an option. As at *sq"əl*, if the shamans were successful hunting in *səx"ləḡab*, the wide prairie, game would be plentiful next fall (Miller, 1992: 11). If hunting was successful at this location, the groups whose painted boards had a snout would offer pieces of meat to each mouth feeding the shamans' guardian spirit (Miller, 1999b: 139). Dr. Bill told Smith how a person knew that they had received meat from the shamans and how this was ultimately verified:

The doctors now formally step out of canoe, land, "they are here." Then they take things they stole, gun or what not, meat, berries: take it in hand and say "Who'll have this meat?" ... Someone yells, "I'll take it." then holds hands out and doctor slowly places it in hand. ... Hold it and pretty soon your hands begin to sweat, get all wet inside and out. Then you know you have it. Later you go out to hunt and you catch deer, you know its true. [Smith, n.d.: MS268:5:2 no. 30]

Sam Wilson, on the other hand, told Smith that the berries, meat, etc., were not given to a person but instead were thrown to various locations that people specified. This would bring plentiful game or berries to the location in the next season. The differences between these two accounts could be the product of intergroup variations: Dr. Bill was Snoqualmie, and Sam Wilson was Suquamish (Smith, n.d.; Miller, 1988). The efficacy of the ceremony, beyond the curing aspects, includes the distribution of health; one is sick, all benefit from their participation.

Next the travelers happen upon *absčəčqsalí*, Mosquito Place. Miller suggests, "Since Mosquitoes were shamans in the spirit world because their ability to suck blood was useful in curing, this encounter was a test of shamanic ability" (1999b: 139). Miller

also suggests that this location “represented the travails of summer camping, the deceptive might of the seemingly insignificant, and the dangers of stagnant water, especially after malaria was introduced from other continents” (1988: 89).³² Furthermore, the mosquitoes in this location may be similar to the mosquitoes mentioned in Coast Salish mythology: “According to legend, the Mosquito was once enormous, but abused his might. In punishment, he was killed and burned, with mosquitos [*sic.*] of the present size being created from his ashes” (Miller, 1988: 89). Miller suggests that “[s]ince the spirit insects were the size of birds, they had more of the character of the mythic Mosquito, reminding everyone of at least one advantage the present world has over the ancient one” (1988: 89).

Old Pierre, a Katzie Coast Salish³³ man, told Diamond Jenness that he knew of a Skokomish shaman who had Mosquito power; but “[t]he man had refused to undergo the long fasting and purification necessary to reach the true home of the mosquito (or any other guardian spirit); consequently he was able to cause illness but not cure it” (Jenness, 1955: 56). Old Pierre’s statement highlights two important aspects of shamanic guardian spirits. The first concerns the level of power as related to the spirit quest: the degree of power granted by the spirit was correlated with “the severity of the suppliant’s penance and the intensity of his purification” during the questing (Jenness, 1955: 65). As Collins points out, “The length of time that one fasted on a quest was directly related to the kind of spirit that one got. More powerful spirits were sometimes earned by fasting for a longer period” (1974: 176). Although the quest for shamanic spirits was fairly similar to

³² For a brief discussion of malaria, and other introduced epidemic diseases see Boyd, 1990: 137-142.

³³ The Katzie people reside on a reserve on the Fraser River in Canada, about 40 kilometers inland from Vancouver, British Columbia.

questing for lay spirits, Elmendorf suggests that it was possible to purposively seek out a shamanic spirit:

Often it was not known by the seeker what type of spirit might appear to him, although purposive quests specifically for shaman spirits might be made. These involved visits to localities considered by the mentor as most favorable for shaman spirits. Among these were the headwaters of creeks, [and] mountain lakes. [1960: 502]

Again we see the connection between water and spirit powers. Old Pierre also explained to Jenness the difficulties inherent in obtaining a guardian spirit who confers shamanic ability:

The greater his sufferings, the more intense his fast, ... the looser became the bonds that united his vitality or mind with his body, so that the former was able to wander to greater distances, and to penetrate beyond the veil of the everyday world to the mystic realm of the unseen. Only the man who had attained this distant realm ... acquired strong enough power to heal diseases. [Jenness, 1955: 65]

One could receive a shamanic guardian spirit without reaching this distant realm, but shamans who did not reach it could only cause disease and not cure them (Jenness, 1955: 65). The duality of shamanic spirit powers, to cure and to injure, stressed by Old Pierre had social implications for a shaman, who holds an ambiguous social position (Elmendorf, 1960: 509).

The next stop along the trail was Beaver Den. If the shamans were successful in killing a beaver there, “the furs would be of high quality the next year” (Miller, 1992: 11). Dr. Bill suggested to Smith that this location provided some comic relief. Some shamans would stick their poles into the beaver houses to goad out the beavers while others waited to catch them as they came flying out of the houses. When a beaver would run out of the house the shamans waiting to catch it would whistle so the others would

know to stop prodding. Sometimes though the prodding shamans would pretend not to hear and a jocular argument would ensue with “lots of laughing and fun, kind of clowning here” (Smith, n.d.: MS268:5:2 no. 30; *cf.* Waterman, 1930: 140).

The Land of the Dead

Although I have discussed the land of the dead in generic terms, it too, was group-specific, reflecting the geographic and experiential situation of the group and the ill. Miller points out that as the party neared the first land of the dead, the shamans acting out the journey in this world would sometimes move to the nearest human graveyard (1992: 12). The physical surroundings of the village of the dead “looked like the location of the nearest human graveyard,” and participants could tailor “the rite according to the characteristics of the participating shamans, the tribe and family of the patient, and the locale where the ceremony was held” (Miller, 1999b: 140).

The village of the dead was further specified. On occasion, the shamans visited the wrong village of the dead. In such circumstances, the shamans would “embark immediately on the correct route to the other abode of the captured entity” (1999b: 141-142), reusing the painted planks they had taken on their aborted journey. Villages in the land of the dead mirrored the villages in the land of the living (Haeberlin, 1918: 254). Dr. Bill told Smith that each person would return at death to the village in the land of the dead that corresponded to the one where they were raised. Thus husbands and wives, if raised in two different villages, would be split up in the land of the dead. Their children would go to the village in the land of the dead which corresponded to the one they were raised in. When the patient’s parents were raised in separate villages, the shamans would

first go to the village in the land of the dead which corresponds with the village that the patient was raised in. If the patient was not found there, the shamans would return to the land of the living and then quickly set off to the other parent's corresponding village (Smith, n.d.: MS268:5:2 no. 30).

The fact that the shamans had to retrace part of the journey before going to another village in the land of the dead is significant. It reflects the ways people travel in the Puget Sound region. For an individual to travel to one village and then to another would most easily be accomplished by retracing part of his or her route so that they could follow another water system. As both Smith (1940: 2) and Elmendorf (1960: 286-288) suggest, the easiest and most customary routes for travel and communication followed water courses. Elmendorf notes that people would also use overland trails where such trails led to either another river or another body of water (1960: 287). The shamans would return part or all of the way back to their initial starting point before heading off to another village in the land of the dead. This travel reinforced the identification of a particular trail with a particular village or group.

Intergroup relations were anchored to the locality in two senses. First, travel and communications followed water courses; and, second, intergroup relations were anchored through distance and intensity of contact. Travel by canoe obviously had to follow rivers. Smith notes that footpaths also followed rivers (1940: 2; *cf.* Elmendorf, 1930: 286-287), as, "It was almost physically impossible to cut directly across country" (1940: 2). Elmendorf, on the other hand, proposes that inland trails were utilized as a convenient way to travel out of an area, but such trails led to the next river drainage system or salt-water inlet (1930: 287). Intergroup contact may have occurred over a vast territory but

there is most likely a decline in the intensity of such contact with ease of contact.

Therefore, much like relations with other people in this world, as ghosts moved from one land of the dead to another, moving further away from the living, knowledge, contact and remembrances of these ghosts decreased. In other words, distance in time is associated with distance in space.

The trail reflected the group's local landscape (Miller, 1988: 98), and also, specific genealogical ties. The patient's genealogy must be expressed, including group affiliations, so that the shamans would know which village in the land of the dead to visit. The production of a genealogy is also important because it plays a role in determining one's level of prestige in the community (Miller with Snyder, 1999: 125; see also Suttles, 1987a, 1987c). Suttles (1987c) suggests that one's genealogy is a component of what he calls "advice" that is necessary to higher statuses. "Advice," as defined by Suttles,

consisted of genealogies and family traditions revealing family greatness, gossip about other families demonstrating how inferior they are, instruction in practical matters such as how to quest for the right kind of guardian spirit, secret signals for indicating that someone is of lower-class descent, and a good deal of solid moral training. [1987c: 8]

Thus, by eliciting the patient's genealogy there was a public display of the patient's claim to status and prestige. There is also an opportunity for change in status by all parties, for as Snyder recorded among the Suquamish, noting a "weak" spot in a person's genealogy could lower their relative rank (in Miller with Snyder, 1999: 125).

It was the better remembered ghosts (*i.e.*, those closer in distance) that posed the greatest danger (Smith, 1940: 97). Smith writes, "The major active menace to the living, ... came from close relatives, deceased from one to twenty years and occurred during the winter months" (1940: 97). Ghosts were most active in the winter in the land of the

living, and thus in summer in their own land (Smith, 1940: 97; Miller, 1999a: 35). The more recently dead would be closer, but as time passed and remembrance began to fade a ghost would pass on further away to another land of the dead, thereby posing less of a threat. In opposition, as an individual in the land of the living moved further away from his/her village or home territory, the level of danger increased. As one came across groups that were less seldom encountered or more distant from an individual's own group, conflict, or at least the expectation of conflict, increased (Suttles and Lane, 1990: 488). Furthermore, as the most defenseless people, including children, the aged or anyone fatigued, moved further away from their home village, they also became more susceptible to attacks by shamans. "In other words," writes Miller, "being out of place, in any sense, was a spiritual hazard" (1999b: 132). A village was a strong anchor for spiritual power, even ghosts congregated around the villages they lived in formerly (Smith, 1940: 97; Amoss, 1978a: 75). As one moved away from their own village, they also moved away from this concentration of spirit power. We have then a correlation between intensity of connection to spirit power and distance. Both the threat posed by a ghost and the intensity of a person's spiritual power decrease as the distance from the home village/territory increases. Thus, Miller argues that power is anchored in the locality and radiates outward (1999b).

Audience Participation

One of the three inseparable elements of Lévi-Strauss's "shamanistic complex" is the involvement of the public. The shamanistic complex

is founded on a threefold experience: first, that of the shaman himself, who ... undergoes specific states of a psychosomatic

nature; second, that of the sick person ...; and, finally, that of the public, who also participate in the cure, experiencing an enthusiasm and an intellectual and emotional satisfaction which produce collective support. [Lévi-Strauss, 1998 [1963]: 134]

In the *sbəltədaq* ceremony, as in most Coast Salish curing ceremonies, the role of the audience is integral to the success of the cure: “You see, a doctor is no good without qʷaqʷáwəd³⁴ (audience help). His power will refuse to work. ... Well, the audience gets behind the doctor and makes more noise in the singing and helps him” (Henry Allen to Elmendorf; in Elmendorf, 1993: 221). Moreover, “[i]n all shaman-curing performances it was desirable to have “audience help” ... to accompany the ... shaman as loudly as possible in his singing and thus create the public ceremonial atmosphere in which his curing powers could most efficiently operate” (Elmendorf, 1960: 505). Although Elmendorf suggests that audience help is desirable in *all* shamanic cures, it appears that the level of help in the various types of shamanic cures among the Coast Salish also varied according to the type of curing being performed. Amoss suggests that one reason for holding private parties, which “are small and usually held at home,” was in cases of illness, where attendees are mainly family and friends (1978a: 90), as in the curing ceremony that the Kews attended, discussed above (Kew and Kew, 1981: 30-31; cf. Smith, 1940: 79-81).

Audience help through singing occurred during the *sbəltədaq* ceremony: “It is said that the spectators sang “to lift up the shamans” ” (Haeberlin, 1918: 253). This notion of audience participation to help “lift up” is found in all public Coast Salish ceremonies. For example, on the final day of Vi (*taqʷšəblu*) Hilbert’s gathering, which I had the honour of attending last summer, her daughter Lois (*yapəntukʷ*) told the story

“Lifting the Sky.”³⁵ The story is set in a time when the sky was so low that people would bump their heads on it. The leaders of various groups got together to figure out what they could do. They decided to lift the sky with poles, but this could be done only if everyone helped. Finally, the day came to act, and everyone lifted together. The sky only moved a little bit higher. Again, everyone lifted. The sky moved a little bit higher. Again, they tried. It was on the fourth attempt that the sky was finally high enough.³⁶ Neither the sky in the story, nor the daylight (according to Dr. Bill) (in Smith, n.d.: MS268:5:2 no. 30), could have been lifted without everyone’s help. Lois also stated that when people gather in the traditional way, everybody lifts each other’s spirits up. There is a sense of this collective support at all Coast Salish gatherings.

Community involvement thus extends far beyond healing: “In public, no one performs alone among the Salish. Everything is done with a sense of community” (Miller, 1988: xvii). Even an individual’s relationship with a guardian spirit requires community support:

It is not possible, ... for a person to enjoy a socially approved relationship with spiritual beings without the support of kinsmen. Without family help he cannot arrange the gatherings, the payments, and the peripheral expenses that are the necessary parts of social validation of his supernatural connection. [Amoss, 1978a: 55]

Elsewhere, Amoss suggests that this help gives the individual dancer a sense of connection to community:

³⁴ This is a word from the Twana language, which is a Coast Salish language closely related to Lushootseed (Thompson and Kinkade, 1990: 35).

³⁵ *yapəntuk* had learned this story from *taqʷšəblu*, who had learned it from William Shelton (see Shelton, 1923: 11-12).

³⁶ An important difference between Northern and Southern Lushootseeds with regards to drawing a connection between lifting the sky and lifting the daylight is that four is the sacred number for Northern Lushootseeds (Hess, 1995: 140), while, as previously mentioned, five is the sacred number in the south (Miller, 1999b: 139). Both *taqʷšəblu* and Lois are Northern Lushootseeds.

Above all, spirit dancing provides the individual with a sense of relatedness to other people. When a person dances the others present gather around him to help. They sing and drum for him. They protect him from the dangers of evil forces by the screen their bodies form around him. They pour their feelings into the singing of his song. [Amoss, 1977: 82]

For, as Amoss heard a prominent speaker state, “As old as I am in the Indian Way, the time has never come when I can get up to dance, and drum for myself” (1977: 82).

Elmendorf suggests that shamanic curing and spirit dancing were similar, in that both “were public ceremonialized exhibitions of guardian-spirit powers” (1960: 506).³⁷

Community involvement extended beyond singing during the performance of all ceremonies. Miller points out, “Everyone in the community was involved in the preparations. Women cooked food and cleaned the house, while men hunted and helped out as needed. Children gathered nearby, ready to run errands and carry messages” (1999b: 136).³⁸ Miller points out that although during the ceremony people would visit quietly amongst themselves, feast, and make speeches, “everyone helping [the shamans] in thought, deed, and song” (1988: xvii). As Waterman points out, “The whole audience helped in the drama” (1930: 543). Dr. Bill told Smith (n.d.: MS268:5:2 no. 30) that in the duel in *absčəcqsali*, Mosquito Place, the shamans did not fight alone, but everyone participated. In the village of the dead, or whenever a ghost was met, it was audience members who filled the role of the ghosts: “Thus, when the war-party reached the underworld and entered the village, the audience took the part of the dead people abiding there” (Waterman, 1930: 543; Haeberlin, 1918: 255; Miller, 1992: 10; Smith, n.d.: MS268:5:2 no. 30). It should be noted that, contrary to this general trend, Frank Allen

³⁷ Both lay spirit power and shamanic spirit power are guardian spirits. For a discussion of the differences between the two forms see, for example, Elmendorf, 1960.

told Elmendorf, regarding his account of a Skokomish journey, that the ghost met along the trail was played by one of the shamans (in Elmendorf, 1993: 228). Finally, the audience played the part of the ghosts, as discussed above, in the battle involving flaming cedar splints (Miller, 1992: 12; Haeberlin, 1918: 255). Thus, the audience was involved in the ceremony not just to see a sick person healed and to provide an atmosphere of collective healing support, they were also an integral part of the ceremony without whom the success of the ceremony would have been compromised.

The significance of performing the ceremony in, most often, the patient's house allows family, friends and community to participate in the healing ceremony. This role of the audience is in contrast to healing in the biomedical context in which the patient is removed from their cultural, familial and social contexts (e.g. Finkler, 1998). The audience, patient and shamans were actively engaged in the process of curing and actively participating, in what could be called "guided rediscovery" (Ingold, 2000a: 4), in the reification and reinforcement of a particular engagement with the world.

The community was also involved in the economic transactions of the ceremony. Sponsors and the host community would gain prestige from their output (Miller, 1999b: 143). As Henry Allen told Elmendorf, "You pay the doctor as much as you can. The more you pay the better people think of you, the bigger man you are" (in Elmendorf, 1993: 233). The payment for a successful cure was quite expensive, since "the patient was expected to give most or all of his or her property to the shamans to pay for the cure of this life-threatening illness" (Miller, 1999b: 143). "Sponsoring the rite, therefore," Miller continues, "was a heavy financial burden on the patient, his or her family, their

³⁸ This involvement continues today. It was readily apparent at the functions I have attended in the Puget Sound region.

house, and the locality” (1999b: 143). Waterman also suggests that the variation in the duration, elaborateness³⁹ and in the number of shamans depended on how much the patient and family were paying for the ceremony (1930: 147). Waterman’s assertion, though, appears to be at least idiosyncratic, for although in most accounts there is some sort of remuneration,⁴⁰ in one account of the ceremony there was no payment at all. Rather, the shamans “worked for the benefit of the whole [group], placing these needs ahead of their own” (William Shelton in Miller, 1988: 11).

In this chapter I have attempted to show how the *sbəltədaq* ceremony reflects and reinforces a particular engagement with the world — a way of knowing that is constituted in a dynamic engagement with the world (Ingold and Kurttila, 2000: 184) — by binding people, health, ancestors and the world together. By viewing the *sbəltədaq* ceremony as a process of generating knowledge I propose that one can better understand the ceremony and also better explain the variability found in the ceremony between groups and individuals.

On the other hand, one *could* argue that such variability is related to cultural variation, as in the attribution of a style of plank to a particular group. It seems, though, that the variation occurs at a more specific level; if we remain at the level of culture in our analyses, internal cultural heterogeneity is difficult to explain. As Haeberlin points out, “the ceremony was bound to be an [intergroup] affair” (1918: 251). This does not necessarily mean that neighbouring groups could perform the ceremony. Instead, these

³⁹ Waterman does not define what he means by the elaborateness of the ceremony, but it may connote the number of locations encountered along the trail.

⁴⁰ For example, Haeberlin writes,

When a poor person was unable to give a [*sbəltədaq*] ceremony, a relative who was a [*sbəltədaq*] shaman might perform the ceremony for him free of charge, and also the other participants. Or a poor man might pay for the ceremony by

alliances were based on common lands of the dead and trails leading to that land. As Haeberlin writes,

When a Snohomish gave a [*sbəłtədaq*] ceremony, shamans from such allied tribes as the Snuqualmi, Skokomish, Sdohobc, etc., would participate. But he would never hire a [*sbəłtədaq*] shaman of the Dwamish or Suquamish, although the latter tribes lived in closest proximity and were linguistically just as intimately related as the other neighboring [groups]. [1918: 251]

Duwamish were allied with the Suquamish — two groups on opposite sides of the Puget Sound — and not with the Snoqualmie or Snohomish, the two neighbouring groups to their north.

Coast Salish marriage practices also help explain some of the variation in the ceremony. Smith suggested that the village unit was a fundamental part of the Coast Salish social structure and described how the same name was used for a village and associated drainage (1940: 6). Suttles asserts, “Individual and family ties were as strong between villages as within the village” (1987b: 219). These intergroup ties between individuals and families were a result of village exogamy being the preferential marriage pattern (Miller with Snyder, 1999: 137). The result of this practice among higher status people “led to most upper-class, blood-kin groups becoming distributed throughout a series of separate village communities” (Elmendorf, 1960: 362). By marrying out, intergroup alliances were formed that maintained the individual’s and their family’s status, but such alliances had important implications for subsistence as well. Suttles suggests that “members of different villages who were united by ties of marriage and kinship also co-operated in the food quest or shared access to other’s resources” (1987b: 219). Furthermore, the practice of village exogamy allowed a freedom of movement

giving his daughter in marriage to a shaman. Then the latter did not give

between the various groups/villages that a family was related into. One result of this freedom was that the Suquamish and Duwamish people did not consider themselves as separate groups (Miller with Snyder, 1999: 144). This closeness between these two groups may be the reason why the Suquamish and the Duwamish could perform the *sbəłtədaq* ceremony together.

The practice of village exogamy is important, in that the patient may have been raised in a different village than the one they reside in. This is why there must be multiple villages in the Coast Salish conception of the land of the dead. The *sbəłtədaq* ceremony is intimately linked with the Coast Salish conceptions of illness, intergroup relations, kinship, marriage, names, status, subsistence, and, most importantly, a particular mode of perceiving and engaging the world. To attribute the variations in the ceremony to variations in the cultures of the groups who performed this ceremony denies these links and glosses over intragroup variations that reflect the specific context of the performance.

In the next chapter I will discuss how the *sbəłtədaq* ceremony and biomedical practices are related. I argue that these sets of practices are not that much different, as both, at the most basic level are ways to restore health.

CHAPTER FOUR: Reunifying Medicines

By asking the question of how the *sbəltədaq* ceremony and biomedical practices are related I have reproduced the ethnomedicine-biomedicine dichotomy. The dichotomy is reproduced in my question through the denial of their common goal: the restoration of health. In this chapter I will discuss how some of the proposed conceptions of experience and knowledge reproduce the division of biomedicine from other medical systems. Then I discuss further the notion of medical systems and practices as being grounded in culture and the implications this notion has in the biomedicine-ethnomedicine dichotomy. Following this discussion I will turn to one aspect of biomedicine that has been suggested as making biomedicine a unique ethnomedicine — technology (*e.g.*, Hahn and Kleinman, 1983: 322-323) — and how the association of technology with biomedicine, and not with other ethnomedicines, is grounded in notions of modernity that reproduce the ethnomedicine-biomedicine dichotomy. Next I revisit the disease-illness dichotomy in medical anthropology, further adding to my discussion in chapter 2 on how this dichotomy hinders the understanding of all medical systems and practices. Drawing on the above discussions in this chapter, I then look at the problems the disease-illness dichotomy has engendered in the biomedical arena. I continue by arguing that limiting “disease,” as formulated in medical anthropology, to biological debility (*e.g.*, Kleinman, 1988: 5-6) not only reproduces the biomedicine-ethnomedicine dichotomy, but is also grounded in notions of modernity. Finally, I will conclude with a discussion of the implications of considering medical systems and practices as a form of LTK versus considering them from the perspective of MTK — which, I argue, is how the

ethnomedicine-biomedicine, the disease-illness, and even the modern-nonmodern dichotomies are created, formulated and reproduced.

Biomedicine, Experience and Knowledge

Although Deborah Gordon qualifies her discussion of what she considers the tenacious assumptions in biomedicine by stating, “First, I do not want to encourage thinking about biomedicine and western traditions in monolithic terms,” for, “[i]f research has demonstrated anything it is the plurality of biomedicines” (1988b: 22). An important variable not considered by Gordon is the role of individual experience. In that her discussion of the tenacious assumptions in a way circumvents individual experience. She is concerned with how these tenacious assumptions form the background of biomedicine (1988b: 20): “Like other aspects of a society’s culture, biomedical discourse and practices operate against and through a background of understandings that are shared to varying degrees with other subcultures in western society” (Gordon, 1988b: 22-23). Furthermore, Gordon suggests, “One participates *through* background assumptions, one does not consciously *see* them” (1988b: 23).

Are Gordon’s tenacious assumptions really the background of biomedical practice? Gordon states that her “intention is to stress ways of being and feeling,” for she envisions the participation through the background assumptions that entail “ways of being and not just explicit beliefs” (1988b: 23). These assumptions are based on a culturally and historically situated “separation between cosmology/ontology on the one hand and epistemology on the other” (Gordon, 1988b: 23). If these assumptions entail a

way of being, these assumptions must, then, presuppose this act of being. As Tim Ingold points out, “our ideas about the world — including those that go by the name of science — are fashioned against the background of our active engagement with its diverse human and nonhuman constituents” (1997b: 232). As throughout this thesis, if Gordon’s proposed assumptions are not fashioned against this active engagement with the world they “would carry no practical or motivational force whatever” (Ingold, 1998a: 178). Lola Romanucci-Ross and Daniel Moerman’s discussion of “clinical judgment” shows how the science in biomedicine is informed by experience:

physicians inevitably use “judgment” when they prescribe treatments, this is to say that “science” (the clinical trial) is tempered by “knowledge grounded in experience” (what we have called “belief”) — these are combined into what physicians call “clinical judgment”. [1997: 356]¹

In other words the clinical trial, when it does not feel right, is tempered by “knowledge grounded in experience.” Romanucci-Ross and Moerman also point out, regarding the clinical trial, “the design of trial necessarily reflects the assumptions and expectations of the investigators” (1997: 357). But as mentioned earlier, Melford Spiro points out, “Nevertheless, however indispensable these subjective procedures may be for the formulation of interpretations and explanations, in the scientific mode of inquiry they are entirely disqualified as a method for their validation,” for, “scientific inquiry requires objective (public and replicable) procedures” (1986: 274). Spiro’s point, though, does not invalidate the use of these subjective procedures; rather these procedures cannot be used as a method to prove validity.

Why, though, can we not consider the *belief* that scientific method is objective or acultural held by scientists etc. as a “belief”? True, there may be more “art” than

“science” in biomedicine (Gordon, 1988a) but practitioners *believe* that it is objective science (Hahn and Kleinman, 1983: 312). Possibly the difficulty in accepting the belief of the objectivity of biomedical knowledge is a result of how “belief” is conceived by anthropologists. Byron Good, in his discussion of the problem of belief in anthropology, wonders how the notion of “belief” came to connote “some aspect of their [members of other societies] world which does not exist in ours and which we are comfortable asserting is not part of empirical reality” (1994: 15). Good states, “From my initial explorations, it would appear that the term “belief” as it is employed in anthropology does indeed connote error or falsehood, although it is seldom explicitly asserted” (1994: 17). Doctors cannot “believe” in biomedical ethos because of the Western conceptions of knowledge. For “[k]nowledge requires both certitude and correctness, belief implies uncertainty, error, or both” (Good, 1994: 17). Good proposes that a hypothesis arises from a brief review of anthropological texts:

Second, belief as an analytic category in anthropology appears to be most closely associated with religion and with discussions of the so-called folk sciences. “Belief” is most closely associated, that is, with cultural accounts either of the unknowable or of mistaken understandings of the “natural world,” where science can distinguish knowledge from belief. [1994: 20]

But as Romanucci-Ross and Moerman point out above — that “the design of trials necessarily reflects the assumptions and expectations of the investigators” — with the result being that the trials “may provided convincing demonstrations of “obvious” but incorrect notions. ... Statistical significance is no assurance against design error” (1997: 357). Thus, although Spiro points out above that these subjective procedures are disqualified as a method of validation, these procedures can be so inherent in the trial

¹ See also Gordon’s (1988a) discussion of the “art” and “science” in biomedicine.

design that they influence the outcomes. Still some anthropologists, such as Spiro, suggest, “an objective ... method is required for deciding whether an [ethnographic] interpretation should be accepted or rejected” (Spiro, 1986: 275; see also D’Andrade, 1976). “The scientific method,” Spiro continues, “which assesses the validity of interpretations by the logical procedure of testing their predictive or retrodictive consequences, constitutes such a method” (1986: 275). Or, for example, how George Armelagos *et al.* defend the use of the biomedical method in the biocultural approach in medical anthropology: “It also provides information on very real biological processes and stresses” (1992: 39).

There are then two perspectives regarding scientific knowledge in anthropology. On the one hand, it provides very real information and provides a method for assessing validity; while on the other, it is grounded in culture or is a cultural system (as discussed in chapter 2). But in neither is it a belief system. Byron Good and Mary-Jo DelVecchio Good (1993) look at how biomedical knowledge is constructed at the Harvard Medical School. Their concern is with “how the medical world, including the objects of the medical gaze, are built up, how the subjects of that gaze — the students and physicians — are reconstituted in the process, and how distinctive forms of reasoning about that world are learned” from a phenomenological perspective (1993: 83-84). Good and Good found that through medical training a student’s experiential world changes: “Thus not only are the patient and the sickness reconstituted through medical education, but the person of the medical student and the normal boundaries of his or her relationships are also transformed in the process of becoming competent physicians” (Good and Good, 1993: 102). Furthermore, Good and Good suggest that although normal interpersonal

relationships with people are in a common-sense way the students struggle to balance this with how they are trained to relate to a patient (1993: 101). It appears from this that students learn a different mode of thought that is used when they are in a physician role while they use another mode elsewhere. Learning this physician mode of thought also involves the training of vision — the “medical gaze” (Foucault, 1991) — that they can jump back and forth from: “Students are quite aware that they are learning an alternative way of seeing, that it is a way of seeing that they can “turn on and turn off”” (Good and Good, 1993: 96). But do doctors really straddle these two worlds?

Good and Good discuss how the individual is reconstructed as an object of the medical gaze, but this gaze is constricted within a circumscribed space (1993: 95). Yet they state, “Students, undoubtedly drawing on cultural images available, describe increasingly experiencing the body as “machinelike” ” (1993: 96). Either Good and Good are suggesting that the “cultural images” that the students are drawing upon are from biomedicine, in the sense that it is a culture, or these images come from the dominant culture. Biomedicine as a culture is a notion that I have, and will further, critique, but the anthropological literature available suggest that these cultural images of the body as machine the students draw upon are from the dominant culture. Although viewing the body as a machine is key to the biomedical enterprise (Good and Good, 1993: 96; Gordon, 1988b) it is not exclusive to “biomedical culture.” Peter Manning and Horacio Fabrega, Jr. suggest, “in modern society, man has adopted the language of the machine to describe his body” (1973: 283; Lock and Scheper-Hughes, 1996: 59-60). Mary-Jo DelVecchio Good (1995) has argued elsewhere that there are global-local exchanges in biomedicine in which local cultural assumptions frame the global biomedical knowledge

and practices: “Rather local meanings and social arrangements are overlaid by global standards and technologies in nearly all aspects of local biomedicine” (Good, 1995: 462). Thus, the global aspects of biomedicine are assimilated into the local biomedicine (Young, 1976: 10). As Allan Young has suggested, “What people get during sickness episodes ... are medical proofs consistent with their expectations” (1976: 9). These expectations, which Young calls “practical explanations”, “answer questions about how medical beliefs and practices work, how they change a sick man’s condition to some more desirable state” (Young, 1976:7). These explanations are framed within the individual’s cultural background, which also, as Kaja Finkler (1998) showed, affects the expectations regarding the healer’s role (Young, 1976).

The argument that biomedicine is a culture reinforces a particular perspective towards knowledge, humans and the world. Furthermore, such an argument represents a double disengagement of biomedicine. First, it places biomedicine up there, outside of life lived in the world; and, second, it removes biomedicine from the cultural contexts (note plural) that it is embedded in — the opposite of what Robert Hahn (1995) etc. were attempting to accomplish. For example, the perspective regarding the body in biomedicine was partly developed through the entry into the body (Foucault, 1991; Good and Good, 1993) but this entry was afforded by a particular cultural and historical context (Foucault, 1991). With the entering of the body, Good and Good suggest that it becomes reconstituted as a “medical body” and the emergence of this body allowed it to become a site of biomedical knowledge (1993: 90).

If biomedical practitioners learn a separate mode of perception does this mean that they have two separate modes of perception, as I have suggested earlier? For if the

entry into the body creates a new mode of perception, which allows the development of biomedical knowledge, this knowledge is particular and attached to the mode of perception it is based on. Thus biomedical practitioners would then hold two separate knowledge systems: their everyday “common-sense” knowledge and their biomedical knowledge.

What I am suggesting here as a separation of knowledge has been proposed by Young. Young proposes that a patient has five kinds of knowledge (1981: 326-327, 1982: 272), as “a way of conceptualizing how a speaker’s knowledge, modes of reasoning and expectations determine the contents and forms of his statements” (1981: 326). He argues that during the sickness episode² these kinds of knowledge “are continually transforming one another. Thus, no one form is, a priori, the speaker’s authentic knowledge of medical events, and no single set of cognitive structures can be said to be the ultimate source of the surface meaning of his statements” (1982: 272). In his latter article, Young also adds two more forms of knowledge that his original scheme describes: prototypes and chain complexes (1982: 272). Prototypes serve as a mechanism “to organize the events and circumstances [people] are experiencing” (Young, 1982: 272). While chain complexes

are products of experience (and possibly unconscious forces): simply strings of empirical events, sensations, symptoms, etc which cohere and persist in the mind because of the salience, contiguity, and chronology of the individual elements in the life of the thinker. [Young, 1982: 273]

Although Young argues that prototypes and chain complexes are limited to a small number of people (1982: 273), these concepts are also quite similar to D’Andrade’s cultural models (1987). For example, like prototypes and chain complexes, cultural models are “composed of a variety of mental processes and states,” such as perceptions,

beliefs, and knowledge (D'Andrade, 1987: 115-116; Young, 1982: 272-273). Cultural models are defined as “cognitive schema that [are] intersubjectively shared by a social group,” (D'Andrade, 1987: 112) and are “composed of a relatively small number of features that define the internal mental states and external objects one needs to know” (D'Andrade, 1985: 321). The intersubjective nature of cultural models gives them “a basic ‘commonsensical’ quality, as if [they] were an obvious outline of reality” (D'Andrade, 1985: 322). A consequence of the common-sensicality of these models is “that a great deal of information related to [them] ... model need not be made explicit” (D'Andrade, 1987: 113). Furthermore, this lack of specificity results in an individual not having a full conception of the whole model: “They *use* the model but they cannot produce a reasonable *description* of the model” (D'Andrade, 1987: 114).

Another similarity between Young's kinds of knowledge and D'Andrade's cultural models is that both are intersubjective (Young, 1981: 326; D'Andrade, 1987: 112). Also, Young's kinds of knowledges are embedded “in a process of knowledge production that the thinker is continually undertaking,” thus they are unstable and context dependent (1982: 272) — much like cultural models. One difference, though, between D'Andrade's cultural models and Young's kinds of knowledge is that while the models provide an “outline of reality” (D'Andrade, 1985: 322) the kinds of knowledge are in a dialectical relationship with each other. To show the dialectical relationship between his kinds of knowledge, Young provides a hypothetical scenario:

For instance, a person's negotiated knowledge of a particular event is made possible by his theoretical knowledge of the class of events into which it fits. But there are also occasions when newly negotiated knowledge becomes theoretical knowledge. This occurs when a patient uses negotiated (diagnosed) knowledge of his or her

² “Sickness episode” is Young's terminology.

ailment to construct a prototype for interpreting future instances.
[Young, 1981: 327-328]

Young's work is important as it holds the same concern with the process of learning medical knowledge as Good and Good had in their analysis of Harvard Medical School (1993: 84).³

Of concern in the context of this thesis, though, is with this portrayal of knowledge by D'Andrade, Good and Good, and Young. Knowledge, thus portrayed, is based on a computer metaphor where knowledge becomes "things held in the mind":

A schema is a mental representation of an object or event. ... Schemata are hierarchically organized, An important thing to stress about schemata is that they are active mechanisms for the interpretation of events and objects — they are processing units, not pictures in the mind. [D'Andrade, 1990a: 155-156]

By defining separate kinds or modes of knowledge, regardless of their interactions, entails that it is possible to think using only one of the kinds while the others lay dormant. To walk around with knowledge in the mind which is sorted, manipulated and then applied (*e.g.*, Bloch, 1994; D'Andrade, 1990b) is suggested by Gordon as being a major tenacious assumption held in science. In her discussion of assumptions in biomedicine, Gordon argues that biomedicine is based on a background of understandings found in Western society: "Like other aspects of a society's culture, biomedical discourse and practices operate against and through a background of understandings that are shared to varying degrees with other subcultures in western society" (1988b: 22-23). Important in the context of the present discussion of the portrayal of knowledge by D'Andrade, the Goods, and Young is Gordon's qualification of her use of "background":

³ Although Young's above quote suggests that he was concerned with the patient's knowledge and not with the practitioner's knowledge.

I do not, however, regard [this background] as understandings or assumptions that people carry around in their heads (consciously or not) and then “apply” in different situations, that is, a cognitive “world view” or a “belief systems.” This view is, in fact, itself a tenacious western assumption. [1988b: 23]

Gordon, in this qualification, is critiquing the portrayal of knowledge discussed above. This perspective on knowledge is also found in Gordon’s (1988b) proposed tenacious biomedical assumptions. Each kind of knowledge, or “schemata” (D’Andrade, 1992),⁴ does not represent all of an individual’s knowledge, the models proposed by Young and D’Andrade are based on the atomism found in biomedicine: “Given that their identity is self-determined, the parts may be removed from their context without altering their identity” (Gordon, 1988b: 26). Young does critique the “Rational Man” writers for focusing on theoretical knowledge but he does this because “there is no a priori reason to suppose that one kind of knowledge is more authentic than the others” (1981: 327). In other words, although Young distinguishes multiple kinds of knowledge — and thus different thought processes — part of his critique is that one should not privilege one of the different knowledge kinds.

Young’s conceptualization of knowledge does allude to some experiential and dynamic aspects to it, but it still portrays knowledge as having discrete parts. For if they were not discrete, Young could not talk about “theoretical,” “empirical,” or “rationalized” kinds of knowledge (1981: 326). Furthermore, its congruences with cognitive anthropology⁵ creates a disengaged perspective of experience: “Actual experience in the real world is then organized by matching it to the prototypical scenarios built into the simplified worlds of the cultural models, and these, in turn, furnish conventional

⁴ D’Andrade defines “schemata” as “a cognitive structure through which interpretations about the world are made,” and are “like flexible templates” that “permit a range of possibilities” (1992: 52).

guidelines for action” (Ingold, 1996a: 104; see also Good, 1994: 51). Young’s model does differ from those in cognitive anthropology slightly in this regard as the knowledges he proposes are more dynamic than, for example, D’Andrade’s cultural models. But the separation, for it they were not separate there could be no relation between them (Young, 1981: 327), as I have argued, entails that one can jump between these different types — much like the biomedical students’ learning to “turn on and turn off” the particular mode of perception (the medical gaze) in biomedicine (Good and Good, 1993: 96). These various, yet similar, conceptions of knowledge are based on what Ingold calls the “genealogical model” which is very closely associated with MTK (knowledge, often traditional knowledge, as conceived from a modernist perspective) (Ingold, 1997c: 8). Ingold calls the model “genealogical” since “this kind of model is implicit in the standard anthropological convention for drawing kinship diagrams” (1997c: 9). Basically, the model “is based on the idea that the elements that go together to constitute a person are passed down, along one or several lines of descent, from that person’s ancestors, independently and in advance of his or her life ... in an environment” (Ingold, 1997c: 9). In other words, this model involves a disengagement from an individual’s experiences. Ingold argues that the genealogical model of knowledge transmission is one of the critical features of MTK (2000a: 2). Thus, Young’s kinds of knowledge are framed within a modernist conception of knowledge: knowledge as segmented and disengaged.

How then is knowledge transmitted from the perspective of LTK (traditional knowledge as constituted within the practices of locality)? First, knowledge as LTK is not transmitted, rather knowledge of this sort arises through a process that Ingold calls “guided rediscovery” (*e.g.*, 1997a: 111). Guided rediscovery is a process “of mixture and

⁵ For example, both Young (1981) and D’Andrade (1991) talk about “prototypes.”

improvisation in the settings of practice. What happens, in effect, is that people develop their own ways of doing things, but in environmental contexts structured by the presence and activities of predecessors” (Ingold and Kurttila, 2000: 193). Thus guided rediscovery is a process of learning and knowledge growth that is situated in the active engagement in the world (Ingold, 2000a: 4). D’Andrade does have a very similar notion, which he calls “guided discovery,” that he uses to explain how much of what is learned is not specified:

While it is the case that people learn most of their cultural programs for representation and action without these programs being specified in detail by the socializing agents, this does not mean that such programs are learned — or could be learned — without any guidance. [D’Andrade, 1981: 185]⁶

The largest difference between Ingold’s notion and D’Andrade’s notion follows from my above critique of D’Andrade’s cognitive anthropological orientation. D’Andrade points out that the things a person discovers, through the learning process of guided discovery are not novel. Rather “[p]art of the method of guided discovery is having ready for the discoverer information about what has been learned, and how it is labeled” (D’Andrade, 1981: 187). Central to D’Andrade’s notion though, is that the discoverer is learning cultural systems. Furthermore, these “discovered” cultural systems “label what is a good thing to know or do, [and] they also classify and label the kinds of errors people make” (D’Andrade, 1981: 187). The transmission of what is good or bad is another difference between Ingold’s and D’Andrade’s notion:

what each generation contributes to the next are not rules and representations for the production of appropriate behaviour but the specific conditions of development under which successors, growing up in a social world, can build up their own aptitudes and dispositions. [Ingold, 1998b: 45]

⁶ See also Bloch, 1994.

In other words, although Ingold and D'Andrade discuss the transmission of knowledge through guidance by others, the purposes of their discussions differ. D'Andrade is attempting to explain how unspecified knowledge is transmitted from a cognitive perspective, while Ingold is discussing knowledge growth set in the contexts of dwelling in the world.

But how is guided rediscovery different than socialization? The concept of socialization in anthropology differs from guided rediscovery in two ways. First, whereas guided rediscovery is a process in which knowledge “is continually generated and regenerated within the settings of people’s skilled, practical involvement with significant components of the environment” (Ingold, 2000a: 4), socialization, as theorized, is based on an assumed disengagement of the actor from the world:

Classically, socialization has been seen as a matter of learning how to categorize others in the social environment as persons of certain kinds, with distinguishable roles, and towards whom certain forms of action are appropriate. This view rests on a theory of indirect perception, long dominant in cognitive psychology, according to which the perceiver cannot access the world directly, but has to figure it out, or to ‘construct’ the world (including the world of other persons) from data received through the senses. [Ingold, 1991a: 371]

Socialization conceived as such reflects the conception of knowledge as MTK in which knowledge is transmitted “like a relay baton to their successors” (Ingold, 2000a: 2). The essential content of knowledge and culture transmitted as such “must be specifiable independently of the actual environmental circumstances that its individual recipients encounter in the course of their lives” (Ingold and Kurttila, 2000: 185). Thus the concept of socialization is firmly embedded in the discourse of modernity. Secondly, the notion of socialization in anthropology has been influenced by the “animal/body plus” conception

of human beings discussed earlier (Ingold, 1997b: 234-238). The image of “body plus” portrays human beings as “constitutionally divided creatures, existing simultaneously as organisms with working bodies and as persons with active minds” (Ingold, 1997b: 234). The influence of this image on the conception of socialization has resulted in human nature being conceived more as a receptacle that needs to be filled and “culture is understood to consist not in forms to be imposed but in content to be acquired” (Ingold, 1997b: 236). “The acquisition of cultural content,” argues Ingold, “is classically described in the social science literature as a process of *socialization*” (1997b: 236). Again we see here in the notion of socialization the conception of knowledge as MTK and the transmission of knowledge based on the genealogical model.

The other critical feature of MTK is the notion of “beliefs” which when taken together establish a “world view” (Ingold, 2000a: 1-2). Framed within MTK, “beliefs” represent “a corpus of rules, recipes and representations, held ‘inside people’s heads’, which serve to organise the data of perception and deliver appropriate plans of action” (2000a: 1-2). Ingold’s use of “beliefs” here is slightly different than my earlier use of the term. I find Ingold’s use of “belief” similar to both Gordon’s point above of how this conception of “beliefs” is a tenacious western assumption, and my critique above of D’Andrade’s and Young’s models of knowledge. Ingold continues, making an analogous point to Gordon’s, “The very notion of worldview ... rests upon a specific ontology that separates mind from nature” (Ingold, 2000a: 2). But this “particular approach to knowledge” is not exclusive to biomedicine: “It is found not only in medicine but in much of western society” (Gordon, 1988a: 268). Interestingly, Gordon (1988a: 268) suggests that it was through the development and spread of computers, which embodies

this conception of knowledge, that this conception was spread — while D’Andrade (1981: 181) suggests that this development of computers was key to the cognitive sciences.

Much like the historical development of biomedical knowledge, a situated cultural context was central to the development of this particular conception of knowledge, which in turn pushed the cognitive sciences forward. These latter two developments were not connected in a linear progression; rather they must have been in a reciprocating relationship, each reinforcing the other: the particular conception of knowledge (with help from the development of computers) allowed the development of theory in cognitive sciences; while these new theories would have helped reinforce a conception of knowledge.

The logic of this relationship is circular, and is similar to the circular logic used by 19th Century evolutionary theorists (*e.g.*, Morgan, 1877; Tylor, 1996 [1871]) to explain cultural universals and the psychic unity of humankind: “Why are there universals of cultural evolution? Because of the psychic unity of humankind. How do we know psychic unity is a valid concept? Because we see common patterns of cultural development” (in McGee and Warms, 1996: 51n). This circular reinforcement was also found in DNA work (Reynolds, 1991). Peter Reynolds discusses how a “web of facticity” (Tuchman, 1978)⁷ was crystallized around a symbolic image/logo: the Double Helix (Reynolds, 1991: 214). The symbol of the Double Helix, proposes Reynolds, “covertly referenced both the A-bombs of Hiroshima and Nagasaki and the caduceus of the medical

⁷ The “web of facticity” is when a group of facts “present themselves as both individually and collectively self-validating. Together they constitute a web of facticity by establishing themselves as cross-referents to one another” (Tuchman, 1978: 86).

profession” (1991: 214-215). The nuclear imagery in the Double Helix created a double reinforcement of the association of nuclear physics and biology:

Because a whole generation of biologists and medical researchers had been for more than twenty years selecting data that emulated the imagery of nuclear physics, using X-rays and radioactive probes, then a condensed image of these unconscious selection processes would, of course, “explain” almost all the data of molecular biology. [Reynolds, 1991: 215]

Reynolds argues, “the theory of life in which the facts of DNA are embedded is not a picture of nature at all but a projection of the unconscious cultural premises that frame the reductionist agenda of molecular biology” (1991: 215). In other words, much like cultural universals proved the psychic unity of humankind, and vice versa, and the relationship between nuclear physics and molecular biology, the conception of knowledge discussed above would have influenced the approach in the cognitive sciences, including cognitive anthropology, which in turn would reinforce the conception of knowledge — similar to Romanucci-Ross and Moerman’s (1997: 357) point above about the influence of the investigators assumptions and expectations in designing clinical trials.

This conception of knowledge is twice situated in modernist discourse. First, the centrality of computers — a “modern” technology — in the development of this conception of knowledge. Second, this conception of knowledge is framed within Western science and ontology. It is through this conception of knowledge that traditional knowledge is portrayed as MTK. Although I have used MTK to also encompass the Western conception of knowledge, Ingold appears to focus on traditional knowledge in his discussion of MTK (*e.g.*, 1997c; 2000a). But it is through the lens of “Western knowledge” that the MTK version of traditional knowledge is created (*cf.* Cruikshank,

1998: 61). Thus, although traditional knowledge as MTK is created through modernist discourse, MTK reflects the conception of Western knowledge. MTK then, represents an attempt to structure other systems of knowledge based on the modernist/ Western conception. Much like Clifford Geertz's and Latour's criticism of some forms of relativism I discussed in chapter 2, MTK represents an attempt by some anthropologists to bring the "nonmoderns" as close as possible to the "moderns." But, following Martin Heidegger (1971: 218), to argue that traditional knowledge as MTK is the same as Western knowledge can only be done if one thinks difference; on the other hand, traditional knowledge can be equal to Western knowledge only through the absence of difference. Ingold's proposal (1997c; 2000a; Ingold and Kurttila, 2000) of conceiving knowledge as LTK — as knowledge arising from a dynamic engagement in the world — is one attempt to equalize various forms of knowledge. To conceive traditional knowledge as MTK then, it *must* be dialectically related to Western knowledge. These two knowledges must be dialectically related for two reasons.

First, traditional knowledge as MTK "reinforces the claim of natural science to deliver an authoritative account of how nature really works" (Ingold, 1998a: 162). The association of this view regarding traditional knowledge with "world view" and "beliefs" reflects and aids in the reproduction of an underlying epistemology, since the term "belief" has come to connote mistaken or fallacious understandings of the world (Good, 1994: 17-21). Moreover, the ontology that separates mind from nature, that forms the basis of "world view," entails a disengagement in knowing (Ingold, 2000a: 2). Ingold's discussion of the image of the globe in current environmental debates provides an example of this, in which this image is afforded through a disengagement of knowing

from the world (1993b; see also Ingold, 1992; Gooch, 1998). In this discussion Ingold distinguishes between the “local” and “global” perspectives of the world. The difference between the two perspectives, argues Ingold, “is not one of hierarchical degree, in scale or comprehensiveness, but one of kind” (1993b: 40). The global perspective presents an image in which “the world appears as an object of contemplation, detached from the domain of lived experience” (Ingold, 1993b: 32). This “global” image has important ramifications in the conception of knowledge. For it allows an individual to transcend “the hapless position of realizing that one’s knowledge is limited,” as Donna Haraway’s (1991) notion of “situated knowledge” suggests, and “of having no way of knowing just how limited it is” (Ingold, 1993b: 36). But this does not mean that the local perspective is limited in the sense that it is a constricted apprehension of the global, but “it is one that rests on an altogether different *mode* of apprehension” (Ingold, 1993b: 40). This different mode is “one based on an active, perceptual engagement with components of the dwelt-in world, ... rather than on the detached, disinterested observation of a world apart” as in the global perspective (Ingold, 1993b: 40). Ingold argues, “[T]o obtain a comprehensive knowledge of the environment, we must already have in mind an image of the globe, ... on to which may be mapped the data of experience” (1993b: 36). The earth becomes a series of “layered surfaces that successively *cover over* one another,” where “life appears to be lived upon the outer surface of the world rather than from an experiential centre within it. The world does not surround us, it lies beneath our feet” (Ingold, 1993b: 37, 40).

From the global perspective, this planet becomes like an “earth plus,” similar to the notion of human beings as “animal plus” (Ingold, 1990a) discussed in chapter 2, in which humanity and its products represent the outer layer, or the “plus,” of the globe:

We discover, here, a direct connection between the notion of the world as a solid globe and the idea, commonly encountered even in anthropological literature, of the environment as a *substrate* for the external imposition of arbitrary cultural form. The world becomes a *tabula rasa* for the inscription of human history. [Ingold, 1993b: 37]

Furthermore, Ingold contends that the global perspective presents a colonial image: “It presents us with the idea of a preformed surface *waiting to be occupied*, to be colonized first by living things and later by human (usually meaning Western) civilization” (Ingold, 1993b: 38). But what does this discussion mean with regards to the conception of knowledge? The separation of mind from the world created by the global perspective results in knowledge viewed as being inscribed onto the earth’s surface, which then just needs to be read — much like reading a textbook: “It is at this surface, the interface between world and mind, ... that all knowledge is constituted” (Ingold, 1993b: 36). Ingold continues that this surface, as conceived from a global perspective, does not have a center: “Anywhere upon it can serve, in principle, equally well as a point of origin or as a destination” (1993b: 36). Ingold is concerned with movement in this latter quotation but it equally applies to scientific or biomedical knowledge.

International development and health programs provide an example of how scientific and biomedical knowledge reflects the global perspective. Paul Sillitoe, in his discussion of indigenous knowledge in development projects, points out, “[S]ome scientists behave as if it were possible to pluck information relating to their specialisms out of cultural context and treat it as independent technical facts” (1998: 228; see also

Williams, 2000). Sillitoe suggests that there is an inherent threat of ethnocentrism when “comparing and contrasting scientific explanations with other people’s understandings of their activities,” and that one of the main contributions anthropologists can make to development projects is to challenge this ethnocentrism (1998: 227). As Dee Mack Williams warns, by pointing out the social and cultural foundation of science, social scientists “seriously problematize prospects for interdisciplinary cooperation” (2000: 507). Kleinman (1986) has also discussed the issue in the context of the social sciences’ influence in biomedicine, in which the social scientist assumes a marginal role. The common reaction by social scientists in biomedical settings is what Kleinman calls “identifying with the aggressor”: “Here the social scientist comes to accept the biomedical stereotypes and relinquishes his own intellectual and professional autonomy” (1986: 229). International health programs provide an example of how biomedical knowledge is conceived from a global perspective through what has been called the “silver platter model,” also described as the “empty vessel” approach, in early health programs. Basically the silver platter model “assum[es] that when developing nations are offered a technique known to work in the donor’s setting, potential recipients would rationally and readily accept this offering” (Hahn, 1995: 272). Note the similarities in this model to the notion of patient compliance discussed in chapter 2, in that both involve power imbalances, with it being “rational” for the recipient groups or patient to follow the dominant donor nation’s or biomedical practitioner’s instructions and “irrational” for them not to. An example of the “silver platter model” is condom promotion in AIDS prevention programs introduced by public health planners in Africa (for a more in-depth discussion see Brown *et al.*, 1996: 209-216). In their analysis of these AIDS prevention

programs, Peter Brown *et al.* found that “efforts to promote behavior change to prevent HIV-AIDS transmission require an understanding of the complex relationship between individual decision making and action and larger social, economic, and cultural constraints” (1996: 215). Condoms were viewed as a simple, risk reducing technology by the prevention program planners (Brown *et al.*, 1996: 214) that reflects the restricted meaning of technology, where technology is viewed as “culturally, morally and politically neutral — that it provides tools independent of local value-systems” (Pacey, 1984a: 2). But Arnold Pacey points out that the use of technology in this restricted sense ignores the wider cultural and organizational aspects — what Pacey calls “technology-practice,” which includes the restricted meaning of technology (the technical aspect) — thereby leaving “a tangle of unexamined beliefs and values” (1984a: 8). These two senses of technology, the restricted and the general, discussed by Pacey reflects Latour’s notion of “hybrids” (1993). Hybrids are networks of things (nature, culture, knowledge, politics, religion etc.) that moderns conceive as separate and unconnected, and also believe that they typify nonmodern people or societies thought (Latour, 1993: 1-5). Thus, the image of the globe, or global perspective, not only provides a colonizing image for the earth, but can also, when applied to scientific and biomedical knowledge, provide a colonizing image for the “nonmoderns.”

The silver platter model, or empty vessel approach, highlights the second reason why traditional knowledge as MTK must be dialectical with Western knowledge. This model/approach is “based on the premise that the recipient nation has no knowledge or practices regarding the proposed intervention, so that the donor simply fills a void” (Hahn, 1995: 272). This belief that a group of people have no knowledge or practices

regarding an event amongst them is part of the ethnocentrism that Sillitoe warned about above: “The lack of respect for others’ knowledge traditions manifested by many Western scientists, [is] underpinned by the assumption that technological superiority implies answers to all difficulties” (Sillitoe, 1998: 227). I will discuss technology in further detail later, but with regards to the current discussion, Sillitoe’s point elucidates the supposed superiority of science in its dialectical relationship with MTK. “For by attributing native understandings to beliefs of questionable rationality, reinforced by the weight of unquestioned tradition,” Ingold points out with regards to MTK, “science’s claim to deliver an authoritative account of the workings of nature ... remains unchallenged” (2000a: 2-3).

Sillitoe’s point also elucidates another aspect found in scientific reasoning. As Stanley Tambiah suggests, “This process of alleged scientific reasoning ... is reluctant, even opposed, to admitting other modes of consciousness or other world orientations into any space it already occupies, for it imperialistically expands to fill all the space available” (1990: 151). Traditional knowledge formulated as MTK fits nicely with this imperialistic expansion of science. Ingold points out regarding this fit, “The scientist may well take the view that one should respect such beliefs, that they have intrinsic worth as indices of cultural diversity, even that they are of adaptive value.... But nothing will persuade [the scientist] that they are actually true” (2000a: 3). Or as Good suggests regarding cross-cultural translations of medical nomenclature/nosology,

However, though important for sorting out sources of cross-cultural misunderstanding, they offer little challenge to the biomedical paradigm and are hardly surprising to clinicians. All are examples of differences in categorization; they illustrate how culture mediates the process of “designation,” of distinguishing among phenomena perceived in the natural world and ordering

them through systems of classification. They are thus easy to subsume within biomedical “hermeneutics.” [1994: 91]

MTK not only supports scientific, and biomedical, knowledge’s superiority and is wrapped up in notions of modernity, MTK also suggests that non-scientific (“science” as conceived by Western standards) cultures/groups/people think differently.

Biomedicine and Culture

The supposed difference in thought between “moderns” and “nonmoderns” is the focus of Latour’s book *We Have Never Been Modern* (1993). A significant difference, as I have alluded to earlier, between the moderns and the nonmoderns is the notion of “hybrids.” The moderns have sliced the Gordian knot, to borrow Latour’s term (1993: 3), and the result has been the segmentation of “modern” society. “The shaft is broken,” writes Latour, “on the left, they have put knowledge of things; on the right, power and human politics” (1993: 3). Or as Tambiah argues in his review of the development of “modern” science, “[T]hese processes in turn have had one major consequence, namely the increasing atomization of modern life into subsystems and domains of purposive rational action” (1990: 151). This process of increasing atomization was not limited to modern life, but this process was, during the same general time period, involved in what Michel Foucault calls one of the “great conceptual conversions” in biomedicine: “In other words, the particular symptom (nervous or hepatic) is not a local sign; on the contrary, it is an index of generalization; only the general symptom of inflammation bears within itself the need for a localized attack-point” (Foucault, 1991: 186). Atomism is one of Gordon’s proposed tenacious biomedical assumptions (1988b: 26-27).

The atomization, or segmentation, of “modern” life/culture/society is the result, hypothesizes Latour, of “two sets of entirely different practices which must remain distinct if they are to remain effective” (Latour, 1993: 10). The first set of practices described by Latour is “translation,” which “creates mixtures between entirely new types of beings, hybrids of nature and culture” (1993: 10). “Purification” is the second set, which “creates two entirely distinct ontological zones: that of human beings on the one hand that of nonhumans on the other” (Latour, 1993: 10-11). Each set is separate yet reliant on the other, which is key, for as long as the two sets are considered separately, Latour suggests then “we are truly modern” (1993: 11). But, “[w]ithout the first set, the practices of purification would be fruitless or pointless. Without the second, the work of translation would be slowed down, limited, or even ruled out” (Latour, 1993: 11). Furthermore, Latour hypothesizes that the practices of purification have made the practices of translation possible: “the more we forbid ourselves to conceive of hybrids [the practices of translation], the more possible their interbreeding becomes” (1993: 12). This is the “paradox of the moderns,” suggests Latour (1993: 12). For the process of hybridization is believed, by the moderns, to typify the nonmoderns and yet it is among the moderns, and not the nonmoderns, that hybrids are allowed to proliferate (Latour, 1993: 6, 12). Thus, although the moderns have nice neat boxes labeled anthropology, politics, science, medicine etc., this segmentation allows the proliferation of hybrids that is constrained, on the other hand, among nonmoderns (other cultures) through their devotion to conceiving of hybrids (Latour, 1993: 12). The belief that the moderns think differently is a fallacy of modernity. As Ingold points out in his discussion of “modern culture,”

But a moment's reflection on the values associated with modernity shows that they add up to the very ideal of rational enlightenment classically epitomised by the concept of civilisation. Indeed the conventional dichotomy between the modern and the traditional does no more than substitute for another which most anthropologists are nowadays ashamed to use, between civilised and the primitive. [1993a: 214]

MTK, with its critical features of belief and world view, is thus inherently opposed to science and biomedicine, as MTK epitomizes a type of knowledge that the laws of nature (science) demolished: "Applying this new critical tool, they no longer saw anything in the hybrids of old but illegitimate mixtures that [the first Enlightenment thinkers] had to purify by separating natural mechanisms from human passions, interests or ignorance" (Latour, 1993: 35). Scientific knowledge became objective, acultural and separate — unlike the knowledges found among other (nonmodern) cultures.

The medical anthropological literature on the "circum-medical field" (Hahn, 1995), or "extramedical cultural beliefs" (Gaines, 1991), provides an example of both the proliferation and denial of the process of hybridization. Hahn defines this field as "includ[ing] the institutions within which medicine is practiced, their physical settings and equipment, their personnel, and the still larger societal organizations of which medicine is a part" (1995: 179). As suggested, the circum-medical field draws on the larger society and culture, which is key to the "biomedicine as an ethnomedicine" proposition: "I claim that Biomedicine is one ethnomedicine among many others, and that, like all ethnomedicines, it is rooted in cultural presuppositions and values, associated with rules of conduct, and embedded in a larger societal and historical context" (Hahn, 1995: 132). Michael Taussig, writing from a Marxist perspective, suggests that the biological (disease) focus in biomedicine "den[ies] the human relations

embodied in symptoms, signs, and therapy, ... not only mystify[ing] them but ... also reproduc[ing] a political ideology in the guise of a science of (apparently) “real things” ” (1980: 3). Taussig continues, “In this way our objectivity as presented in medicine represents basic cultural axioms and modulates the contradictions inherent to our culture and view of objectivity” (1980: 3).

Medicine as reproducing a political ideology, *qua* an instrument for social control, is the focus of Irving Zola’s 1972 essay, *Medicine as an Institution of Social Control*. Zola argues that biomedicine has an influential role in social control through the increasingly (bio)medicalization of life by the process of “making medicine and the labels ‘healthy’ and ‘ill’ *relevant* to an ever increasing part of human existence” (1972: 487). As I suggested in the previous chapter, in the context of this thesis I am more concerned with medical practices’ role in the constitution of lived experience — although Taussig and Zola have valid points and points that need examination, the critical medical anthropology (CMA) perspective that is informed by the perspectives represented by Taussig and Zola (Baer, 1993: 299; see also Good, 1994: 57; Singer *et al.*, 1986) has undergone heavy criticism (*e.g.*, Gaines, 1991, 1992; Good, 1994: 59-62; Morgan, 1987; Wiley, 1992; see also Latour, 1993: 36 for a general critique of the Marxist perspective). Latour suggests that the Marxist perspective — the footsteps followed in CMA (Baer *et al.*, 1986: 95) — is not only solidly grounded in modernity, which provides their ability to criticize, but also supports modernity:

Solidly grounded in the transcendental certainty of nature’s laws, the modern man or woman can criticize and unveil, denounce and express indignation at irrational beliefs and unjustified dominations. Solidly grounded in the certainty that humans make their own destiny, the modern man or woman can criticize and unveil, express indignation at and denounce irrational beliefs, the

biases of ideologies, and the unjustified domination of the experts who claim to have staked out the limits of action and freedom. [Latour, 1993: 36]

Furthermore, Atwood Gaines suggests that CMA writers “seek explanations in experience- and culture-distant terms,” resulting in the omission of “the critical factors in health and illness,⁸ the *phenomenal persons and groups* wherein *human experience* and intersubjective (not subjective) realities are constructed” (1991: 243; emphasis added).

Finally, CMA is not concerned with ethnomedicines; rather CMA authors are more concerned with biomedicine and capitalist exploitation:

Although we do not oppose research on social relationships and small communities (indeed we see it as an essential component of a critical medical anthropology), we maintain that it must be conducted with the recognition that disease, illness, and treatment occur within the context of the capitalist world system. [Baer *et al.*, 1986: 95]

Although Hans Baer *et al.* do acknowledge how essential the study, of what they call, “tribal” and “pre-capitalist” people is to CMA, it does not appear that it is an essential component to their own research: “*We hope that other anthropologists* will extend a critical perspective to tribal and pre-capitalist societies” (1986: 95; emphasis added). The use of capitalism as a starting point for CMA (Baer *et al.*, 1986: 95) and the position that “in the final analysis, macrolevel structures and processes are dominant” (Singer, 1986: 128) does not aid in understanding other medical systems. Nor does CMA overcome the biomedicine-ethnomedicine dichotomy, for as Latour suggests above, to be able to “criticize and unveil, denounce and express indignation at irrational beliefs and unjustified dominations,” one must be solidly grounded in modernity (1993: 36).

Gaines proposes, on the other hand,

Medical systems should [*sic.*] be seen as novel recombinations of existing ideological and practical elements of the local culture and, in some cases reworked elements from other cultures. ...
[M]edicines are systems of knowledge and understanding, criteria for interpreting and constructing culture members' sickness experiences. [1991: 243]

"It is in the constitution of such experience," Jean Comaroff (earlier) suggested, "that medicine assumes a privileged role" (1982: 63; Gordon, 1988b: 41). Similarly, Arthur Kleinman suggested that the recording of the medical case by a biomedical practitioner is a secular ritual, similar to religious rituals, in that the recording of the case plays a role in the constitution of the individual's experience: "it formally replicates a social reality in which core values are reasserted and then applied in a reiterated, standardized format to a central problem in the human condition" (1988: 131). Discussions of the "circum-medical field," whether explicitly or implied in discussions of sociocultural incursions into biomedicine, reflect Latour's "hybridization" as all the authors discussed above, including the CMA authors, are attempting to "retie the Gordian knot." How then do discussions of the circum-medical field deny the process of hybridization?

The two sets of practices described by Latour, translation and purification, are at work in circum-medical field discussions. The practices of translation do allow the hybrids that such discussions allude to, yet the practices of purification are also at work. Comaroff herself points out,

By definition, the category "medical anthropology" implies that the parent discipline comprises a certain sort of intellectual morphology, one which corresponds to a notion of society as the sum of substantive and functionally discrete "sub-systems", modelled after Western institutional forms. Like the anthropology of political, legal and religious systems, the anthropology of medicine expresses what is, at base, a Western essentialist view of

⁸ Gaines' use of "illness" here appears to be analogous to Kleinman's (1988: 3) and Hahn's (1995: 28) usage of the term.

the world, for its focal phenomena are frequently assumed to have certain universal, intrinsic qualities. [1983: 4]

The essentialist basis found in some of the medical anthropology literature allows medical systems to “be unproblematically and justifiably separated from [*sic.*] their socio-cultural contexts for the purposes of description and comparison” (Comaroff, 1983: 4). Thus the “biomedicine as an ethnomedicine” proposition does not facilitate comparison, in fact one could argue that it reproduces the modern-nonmodern dichotomy, and still privileges scientific explanation.

“Biomedicine as an ethnomedicine,” which encompasses the circum-medical field, reproduces modernity through the separately conceived practices of translation and purification as just discussed. Yes the “biomedicine as an ethnomedicine” proponents do, in a sense, discuss hybrids, but the grounding of biomedicine in cultural practice can only be achieved by bracketing off nature (Latour, 1993: 104; see also Ingold, 1992). Thus, biomedicine is disengaged from the world on both sides: if biomedicine fully embodies the scientific ethos (of a disengaged, acultural observer), biomedicine is inherently disengaged; if biomedicine is grounded in culture, this can only be achieved, as Latour suggests above, by disengaging it from nature.

Furthermore, is biomedicine grounded in culture in the same way, or level, as ethnomedicines are said to be? Both Latour (1993: 100-103) and Ingold (1993a) make the similar suggestion that to be able to study other cultures, versus our own culture, dissociates the observer from those people: “If in the very act of identifying a form of life as a culture we dissociate ourselves from it” (Ingold, 1993a: 213). Ingold suggests that if this dissociation occurs “the very notion of ‘our culture’ must be a contradiction in terms” (1993a: 213). Latour proposes that the sacrifice of exoticism that occurs when

“anthropology comes home from the tropics” is overcome “by studying only the margins and fractures of rationality, or the realms beyond rationality” (1993: 100). Latour even suggests that biomedical studies are an excellent example, and field study topic, of how anthropology overcame this loss of exoticism (1993: 100). In nonmodern cultures, suggests Latour, even if the anthropologist assumes a marginal position, for whatever reason, “she nevertheless claim[s] to be reconstituting the centre of those cultures: their belief system, their technologies, their ethnosciences, their power plays, their economics — in short, the totality of their existence” (1993: 199). Upon returning to the modern world, Latour suggests that the full grasp of other cultures becomes limited with anthropology “picking up the crumbs that fall from the other disciplines’ banquet table” (1993: 100-101). Proposing that biomedicine is a culture not only exoticizes it, it also means that it is the same as Coast Salish culture, for example. But an important difference is that the Coast Salish medical practices are subsumed within Coast Salish culture.

One could argue that I am discussing an extreme perspective regarding biomedicine and culture, suggesting that biomedicine does not form its own culture, rather that it is rooted in the dominant culture. But what is this dominant culture? Canadian culture? North American culture? *Our* culture? Regardless, there is a dichotomization of cultures in which the culture associated with biomedicine is differentiated from other cultures. Many authors, though, have pointed out that “biomedicine” is not a homogenous entity (*e.g.*, Gaines, 1991; Mol and Berg, 1998), which is a logical assertion as neither is any culture. But does the variation in biomedicine correlate with the cultures it is found in? We would then have, for example,

“ethnomedicines of Asia, Europe or North America” (Gaines, 1991: 240). Now we run into the problem of biomedicine being homogenous within North American or Asian cultures (whatever these are). Where has this culture that biomedicine is supposedly grounded in gone? Grounding biomedicine in “culture” creates a meta-culture, in that it is found throughout the globe yet is located up there (possibly in the sky?), since biomedicine cannot be the exclusive province of one culture.

Thus, conceiving of biomedicine as grounded in, or as, a culture, disengages it from nature and the world. This, in turn, reifies the biomedicine-ethnomedicine distinction. On the other hand, ethnomedicines are also associated with culture; does this not disengage them from the world? Following my argument above, the answer should be affirmative, yet, as Robert Voeks and Peter Sercombe suggest, “Folk ethnomedical systems underscore the profound interplay between nature and culture at one of its most fundamental levels” (2000: 679; see also Anyinam, 1995). Viewed as such, ethnomedical practitioners become portrayed as, what Ann Fienup-Riordon calls (1990), “original ecologists.” Julie Cruikshank suggests that models based on the notion of “original ecologists” are “more conventionally phrased in religious terms, [and] posits indigenous peoples as stewards of profound ecological knowledge” (1998: 61). Charles Anyinam’s 1995 paper exemplifies the “original ecologist” model, as he examines “the links that ... exist between ethnomedicine and ecology, focusing particularly on the relationships between ethnomedical practices and environmental degradation as well as conservation” (1995: 321). As Anyinam suggests in this quote he is concerned with the link between ethnomedicine and environmental degradation, but this link is not a result of the

“traditional” ethnomedical practices, rather the link with degradation is a result of incursions by the moderns:

While ethnomedicine, especially its religious elements which generally do shape the value systems, attitudes and behaviour of indigenous people towards a positive relationship with nature, modern developments appear to be steadfastly eroding the ‘core of respect’ that is bestowed on nature. [Anyinam, 1995: 327]

Anyinam illustrates the view that indigenous people lived in a harmonious relationship with the world before the moderns arrived (Cruikshank, 1998: 59). We are back at the traditional/nonmodern-modern dichotomy.

The Role of “Technology”

Anyinam and Voeks and Sercombe pose an interesting question: Are ethnomedicines more intimately connected to the world than biomedicine is? How can one deny the important role that flora, fauna and place often play in many ethnomedicines (Anyinam, 1995: 322), as compared to the technologically laden biomedicine (*e.g.*, Casper and Koenig, 1996)? If religion is intertwined with ethnomedicines (Anyinam, 1995: 321), technology has displaced “the force and authority of religious doctrine” in biomedicine (Franklin, 1990: 44). We have returned to the question I asked at the beginning of this chapter: How then are biomedicine and ethnomedicines related? Even asking this question reproduces the modern perspective, as Comaroff suggests above regarding medical anthropology (1983: 4-5). The notion of traditional ecological knowledge (TEK) provides an example of how native/indigenous/aboriginal peoples’ knowledge and culture is redefined in Western

terms, which Ingold argues, “systematically misrepresent the ways in which they actually come to know the world around them” (2000a: 1; Cruikshank, 1998: 61). Furthermore, the notions of TEK and ethnomedical knowledge deny the networks of hybridities that they are embedded in, reproducing the modern-nonmodern dichotomy (Latour, 1993).

The modern-nonmodern dichotomy is further reproduced if one considers biomedicine as technological and ethnomedicines as not. “But *sbəltədaq* only involves some wooden objects,” one could argue, “while biomedicine has machines that can look inside a person or even keep us alive.” This line of argument reflects what Pacey calls the restricted meaning of technology, in which technology “is then identified entirely with its technical aspects” (1984a: 5). Technology, in this restricted sense considers technology only as artifact thereby associating technology “to objects manufactured through complex industrial systems of production” (Ridington, 1994: 273). Robin Ridington criticizes studies of technology for also focusing on artifacts thereby reproducing the modern-nonmodern dichotomy (1982: 470; see also Ingold, 1999: viii). Ridington proposes that “technology” should be considered as artifice, in which “technology [is] ... seen as a system of knowledge rather than an inventory of objects” (1982: 471; see also Ingold, 1988: 157-159). In medical anthropology there appears to be a movement to consider technology as artifice, or in the more general meaning (Pacey’s “technology-practice” (1984a: 5-6)).

Monica Casper and Barbara Koenig propose, “Western biomedicine and technologies are powerful focal points through which to examine key anthropological issues such as meanings, ideology, knowledge, power, and culture” (1996: 523). Casper and Koenig suggest, “there are important reasons why anthropologists and others should

take Western biomedicine and its technologies as a core analytic concern” (1996: 524). One of these important reasons is that through the application of technology in biomedicine “[h]ealth, illness, and disease⁹ may be reframed and redefined, [and] given potent new meanings” (Casper and Koenig, 1996: 524). Although Casper and Koenig (1996) do not explicitly discuss ethnomedicines, it appears that through their use of a more general meaning of technology they also suggest that a concern with technology is also applicable to ethnomedicines.

But a key point of divergence arises here between Ridington’s discussion of technology as artifice (1982, 1994) and Pacey’s general meaning of technology (1984a). Pacey’s general meaning of technology corresponds more with Casper and Koenig’s use of the word, both of which are still object oriented. On the other hand, Ridington proposes, “[T]here are strong suggestions that mythic beliefs and practices might be viewed as a form of technology” (1982: 470-471). Through his work with the Dunne-za, a native group in the North American subarctic, Ridington found that knowledge was more valued than material objects due to the necessity of mobility that typifies hunting communities. “With knowledge,” Ridington argues, “a person can use environmental resources to make material objects as they are needed at a particular time and place” (1994: 281). The object-centered focus, of which Pacey and Casper and Koenig are examples, led Ingold to strongly declare, “*there is no such thing as technology in so-called primitive societies*” (1990b: 6). Ingold is not denying that such people have tools or technical skills, rather his “point is that the concept of technology, at least in its contemporary Western usage, sets out to establish the epistemological conditions for society’s control over nature by maximising the distance between them” (1990b: 6; see

⁹ Casper and Koenig do not define what these three terms allude to.

also Ridington, 1994: 274-277).¹⁰ This distancing from and control over nature embodied in the contemporary Western usage, what Reynolds calls the “technocratic world view” (1991), has two related implications: first, this usage reifies the modern-nonmodern dichotomy by drawing in the notion of “progress”; and, second, leads us back to Ingold’s (1993b) discussion of the global perspective.

Pacey states, “It is understandable that in thinking about particular machines ... we habitually focus on hardware rather than human activity” (1984b: 13). Pacey warns readers that when thinking about concepts like “progress” it makes less sense to focus on the hardware aspects. “Yet,” Pacey continues, “there is a long history of identifying the overall progress of technology with specific inventions or with other strictly technical advances” (1984b: 13). But this is exactly what has and continues to be done (*e.g.*, Linton, 1945; Franklin, 1990). Reynolds calls this association of progress with specific inventions or technical advances the “technocratic theory of history.” This theory of history portrays a linear development of society in which as time passes the separation of nature and culture increases. Thus nonindustrial or small-scale societies are

closer to nature and earlier in time than ourselves, whereas industrial societies, in contrast, are not only part of the present, that is, “modern,” but are on the road to the future as well, which they are actively creating through the reciprocal institutions of science and technology. [Reynolds, 1991: 11]¹¹

Anyinam (1995), discussed above, provides a medical anthropological example of this technocratic theory.

¹⁰ Please note that although Ingold may use “society,” this usage is not in contrast to “culture,” as is reflected in the differentiation of social and cultural anthropology as distinct fields in anthropology: “I believe this distinction is already widely regarded as obsolete” (Ingold, 1998b: 23).

¹¹ See also Pacey, 1984b: 24; Franklin, 1990.

the division of biomedicine and ethnomedicine, hindering the possibility of understanding various medical systems and practices equally.

Revisiting Disease and Illness

As has been previously mentioned, disease is contrasted to illness in medical anthropology, with disease formulated in biologicistic terms making it the exclusive province of biomedicine while illness corresponds to the subjective interpretation of the disease by the patient (Kleinman, 1988: 3-6). But the distinction of disease and illness, it can be argued, became “a radical contrast between the “knowledge” of biomedical practitioners and the “belief” of patients ... and of ... non-Western healers” (Hahn, 1984: 2; Good, 1994). These terms, as currently formulated in the medical anthropological literature discussed, inherently maintain a division between biomedical and non-biomedical practitioners, due to the association of subjectivity with ethnomedicines and the patient. From this perspective the non-biomedical practitioners’ diagnostic capabilities appear to be no better than the patient’s. Thus, disease and illness, as formulated in medical anthropology, maintain the ethnomedicine-biomedicine dichotomy. But “disease” was not always associated so exclusively with biology. Erwin Ackerknecht, writing in 1958 points out, “what is disease, is in the last instance not a biological fact, but a decision of society — what is regarded in one culture as disease, might not be so in another one” (1958: 3; see also Garro, 2000). Ackerknecht may not have drawn a distinction similar to Kleinman’s, but what is important is Ackerknecht’s point that biological disorder does not necessarily equal disease. At some point in the

development of medical anthropology, when medical anthropology “returned from the tropics” (Latour, 1993: 100; *cf.* Mol and Berg, 1998: 4-5), “disease” became associated with biological facts, widening the gap between “modern” biomedicine and “traditional” ethnomedicines. Comaroff describes how the “popular distinction between “disease” and “illness” ” was viewed as the solution to the problem of medicine as an ethnographic category. Comaroff argues, though, that the concepts of disease and illness “are in fact “transformations” of our own Western epistemology, whose very categories are powerfully reinforced by the forms of our own ethnomedical system” (1983: 8). Or as Lorna Amarasingham Rhodes has pointed out, “the disease-illness distinction is a variant of the mind-body and culture-nature dichotomies,” that are fundamental dichotomies in biomedicine¹² (1996: 172). Rhodes warns,

By using [the disease-illness distinction] to separate natural facts from cultural constructions, medical anthropology runs the risk of taking on characteristics of biomedicine itself. Instead of offering a perspective that comes from a position of stranger, the anthropologist may be a kissing cousin in disguise. [1996: 172]

In other words, the application of the notions of “disease” and “illness,” as currently formulated by some medical anthropologists, to other non-biomedical medical systems represents an imposition of Western categories and constructs, much like that presented in my discussion of technology. Furthermore, Linda Garro suggests that the use of biomedical labels (disease) in cross-cultural analysis “essentially sets a boundary around the range of causal possibilities and implicitly conveys that the illness is best treated by a [biomedical] physician” (2000: 321). The crucial question becomes, proposes Comaroff, “how is it possible to identify [local conceptions of illness] in a way which frees us (as much as possible) from our own ethnocentric assumptions about biophysical

¹² See Gordon, 1988b.

individualism, unifactorial etiology, empirically perceived efficacy, ideal and material dichotomies, and so on?" (1983: 8). One way that may help free medical anthropologists from this problem is, as mentioned in the preceding chapter, the expansion of the notion of disease.

As discussed earlier, although disease and illness are distinguished, this does not separate one from the other. Rather, disease represents a transformation of illness:

The healer — whether a neurosurgeon or a family doctor, a chiropractor or the latest breed of psychotherapist — interprets the health problem within a particular nomenclature and taxonomy, a disease nosology, that creates a new diagnostic entity, an 'it' — the disease. [Kleinman, 1988: 5]

The transformation of illness into a disease not only represents a contrast in perspectives, as suggested by Hahn in the preceding paragraph, but the distinction of disease and illness represents an internal division similar to that of the modern-nonmodern division. Biomedicine is modern and objective, while ethnomedicines are nonmodern since they are grounded in belief and subjectivity (Good, 1994; Waldram, 2000). The patient's perspective (illness) position on this medical system continuum is closer to the ethnomedical/nonmodern end, due to the subjectivity of the patient's perspective. We have come full circle back to the knowledge hierarchy I discussed in chapter two. This knowledge hierarchy/continuum has implications for Young's kinds of knowledge discussed earlier in this chapter (1981: 326-328, 1982: 272f.).

Young's distinction of various kinds of knowledge appears to refer to the patient's knowledge in a biomedical setting:

A statement about sickness is a moment in a process in which the speaker is producing knowledge for himself and others. To learn the meaning of his statement, we must be able to re-insert it into this complicated process and articulate it with the forms of

knowledge and modes of reasoning which determined it. [Young, 1981: 322]

If these kinds of knowledge refer solely to the patient, Young has dichotomized the biomedical practitioner/scientist and the patient/individual by implying that the patient thinks differently than the practitioner or scientist — similar to the supposed differences in thought between moderns and nonmoderns (Latour, 1993). One could now argue, though, if the patient does indeed think differently than the biomedical practitioner that biomedicine is a culture. But one must be careful in the use of the term “think”. In one sense, to say that two people “think” differently regarding something can mean that they have differing perspectives regarding the thing. On the other hand, to say that two people “think” differently, as in Latour’s (1993) discussion of how moderns have constructed the nonmoderns as thinking differently, connotes differences in cognitive processes (i.e. the biomedical practitioner “thinks” scientifically while the patient “thinks” subjectively). But if the biomedical practitioner, or the scientist, does not think differently than the patient, in the sense that the practitioner or scientist also have Young’s kinds of knowledge, the practitioner must use one, or some, more than the other kinds. If the practitioner does not use some kinds more than others, and the ones used more would be the kinds of knowledge that correspond to scientific reasoning, there would be no difference between the practitioner and the patient in terms of knowledge.¹³ Thus either the biomedical practitioner thinks differently, in which Young’s knowledges do not apply, or some of the kinds of knowledge must be privileged in the practitioner’s thought, which contradicts Young’s statement, “Nevertheless, there is no a priori reason to suppose that one kind of knowledge is more authentic than the others” (1981: 327).

Either way Young distinguishes the practitioner from the patient in a manner similar to the way the disease-illness distinction as discussed in this thesis.

An important question comes up as a result of the differentiation of practitioner-patient and disease-illness: How does a biomedical practitioner experience ill-health? Hahn addresses this issue in his chapter entitled “Between Two Worlds: Physicians as Patients” (1995: 234-261) where he looks at how practitioners deal with their experiences of the sick role. But I would like to discuss this issue in light of the disease-illness distinction. If illness, as conceived in medical anthropology, corresponds to the patient’s experience or perspective, while the biomedical practitioner transforms this “illness” into a “disease,” the question becomes does the practitioner experience ill-health as illness or as disease? Importantly, Kleinman points out, “From the patient perspective, ... disease and illness are usually not distinguished” (1980: 356). The ill practitioner is technically a patient, does this mean that the practitioner *qua* patient does not distinguish disease from illness or do they? If the ill practitioner does distinguish between the two, what are the ramifications for the practitioner’s experience of his/her ill-health? Does disease feel differently than illness? The only possible change in experience that the transformation of illness into disease could make is through treatment. But both the transformation and the treatment are inherently based on the process of labeling. As Kleinman suggests above, the biomedical practitioner transforms the patient’s illness into an “it,” which in Kleinman’s discussion is a disease (1988: 5). Biomedical labels (disease nomenclature) not only creates an “it” and structures the subsequent treatment (which is dictated by the label) labels also shape the experience of the health problem. Labels shape experience by

¹³ The issue of dominance in the clinical encounter would still provide a means of differentiating practitioner from patient (e.g., Baer, 1993; Finkler, 1998).

giving the health problem meaning through, as Nancy Waxler argues, the socialization of the ill individual into the role that is expected of them by society (1998: 154; Kleinman, 1980: 76). Note how Waxler's argument is similar to Ackerknecht's concerning "what is [a] disease, is in the last instance not a biological fact, but a decision of society" (Ackerknecht, 1958: 3). Labels, following Waxler's point, represents what a society decides is ill-health, which, as Ackerknecht suggests, is not necessarily a biological fact.

My experience with Attention Deficit Disorder (ADD) provides an example of how labeling and treatment can transform experience and how labeling represents a society's notion of what is abnormal (ill-health). Before I was diagnosed, and thus labeled, as being ADD I thought that I was like everyone else. Upon being labeled (diagnosed) I began treatment, which affected the way I experienced the world. Although the biological etiology of ADD is still unknown (Ebert, n.d.), and "disease" and "illness" do not work as well when applied to mental disorders, I still experienced the transformation that occurs when the biomedical practitioner interprets the patient's illness. One way that the diagnosis affected my experience was in my re-evaluation, and re-interpretation, of all of my experiences, both past and present, in light of the meanings that the label provides, as discussed above. ADD also provides an excellent example of Taussig's (1980) and Zola's (1972) arguments above of how biomedicine is becoming an method of social control, or that it reproduces a political ideology, "by making [bio]medicine and the labels 'healthy' and 'ill' *relevant* to an ever increasing part of human existence" (Zola, 1972: 487). As Eberhard Mann *et al.* conclude in their study of cross-cultural differences in biomedical practitioners's rating of ADD, "The results from the present study show substantive and reliable differences in ratings of hyperactive-

disruptive behaviors in children among mental health professionals from four different countries” (1992: 1542). These authors suggest, “[T]he disparities are more likely due to differences in perception than to any differences in actual symptom level. *This may reflect different cultural standards for appropriate childhood behaviors*” (Mann *et al.*, 1992: 1542; emphasis added). In other words, ADD as a diagnostic category can, in some cases, represent the medicalization of behavior for the purpose of social control.

Does this process of labeling, the transformation of illness, only occur in biomedical contexts? If disease is considered solely in biologicistic terms (*e.g.*, Kleinman, 1988: 5) the answer would be a resounding (modern) “Yes.” But then disease, so formulated, does not exist in any other non-biological, and thus nonmodern, medical system and this is why the distinction of disease and illness in medical anthropology maintains the biomedicine-ethnomedicine dichotomy. If, on the other hand, we remove the shackles of biology from disease, and consider “disease” as what *any* form of medical practitioner, be they biomedical, spiritualist or shamanic etc., treats — the transformation of the patient’s illness — we have a global epidemic! For example, amongst the Coast Salish discussed in the preceding chapter, the individual often knows that they are ill (*e.g.*, Smith, n.d.: MS268:5:2 no. 30) — which is not exclusive to the Coast Salish peoples, for as Kleinman points out, “In the United States and Taiwan, roughly 70 to 90 percent of all illness episodes are managed within the popular sector” (1980: 50; Zola, 1972).¹⁴ It is the shaman though, among the Coast Salish, who determines that the sbəltədaq ceremony described in the preceding chapter is necessary (*e.g.*, Smith, n.d.: MS268:5:2 no. 30). Although the “it” created, in this situation, by the shaman is more of

¹⁴ Kleinman describes the popular sector “as a matrix containing several levels: individual, family, social network, and community beliefs and activities” (1980: 50).

a descriptive label, it is, regardless, still an “it.” Thus the shaman transforms the patient’s illness into a “shackle-less” disease.

Conclusions: Medical Systems as LTK

In closing, if we consider knowledge as MTK, which “consists of items of knowledge that are stored in memory, from which they may be accessed and expressed in practice,” (Ingold, 1997c: 10) we restrict our ability to understand medical systems and practices. Knowledge, viewed as MTK, becomes static due to its mode of transmission (based on the “genealogical model”):

People are supposed to receive their knowledge, as it were ready-made, from their predecessors, and likewise to hand it on like a relay baton to their successors. Thus, regarded as substantive mental content, it is in the nature of MTK that it should stay the same from one generation to the next. ... The knowledge itself is therefore context-independent. [Ingold, 2000a: 2]

Two further implications arise if we consider knowledge as MTK.

First, problems arise with regards to the notion of “culture.” Due to the static nature of knowledge as MTK internal diversity cannot readily be explained. It is this problem, in terms of the “fallen unities” of biomedicine and science, that Mol and Berg’s (1998) introduction to *Differences in Medicine* attempts to deal with. Mol and Berg discuss two ways to conceive of diversity: as a problem or as having an underlying unity (1998: 7). But the problem lies in the approach to the problem. As Ingold suggests, “The world does not exist, ... in order to support our theories, rather our theories should help us to understand what goes on in the world” (1991b: 244). Mol and Berg state that the unity of biomedicine “began to crumble when anthropologists started to undertake

empirical studies of health care within North American and Europe” (1998: 4). But to study diversity as a phenomenon (even conceiving diversity as having an underlying unity) retrospectively does so with a world that exists for theory. To explain diversity after the fact maintains dominant presuppositions regarding knowledge etc. If we view knowledge as LTK (as knowledge generated and sustained within the practices of locality), on the other hand, diversity is more easily explained. Since LTK is conceived of as arising from the dynamic engagement with the world (Ingold, 1997c: 10), culture, knowledge etc. *must* be internally heterogeneous due to their basis in experience and in the engagement with the world. Each person will have distinct, or at least not identical, experiences and engagements in the world.

How then do we have phenomena that could be called “cultural” from the perspective of LTK? The answer lies in the notion of “guided rediscovery”:

Just as the craftsman learns his trade by working under the eye of a more experienced practitioner, so the novice hunter-gatherer learns about plants and animals by travelling in the company of knowledgeable elders, who will point things out along the way. The objective is for the novice to get the feel of the country, and a sensitive appreciation of the beings that dwell in it, by engaging with them directly. In every generation people develop their own ways of doing things, but in environmental contexts structured by the presence and activities of predecessors. [Ingold, 2000a: 4]

This sensitivity and responsiveness born out of learning through guided rediscovery can also be called, as Ingold argues elsewhere (1998a: 178), “intuition.” To argue, though, that guided rediscovery only applies to craftsmen, hunter-gatherers etc. and not to “Westerners” reifies the modern-nonmodern dichotomy,¹⁵ but, in this case, the nonmodern is privileged. Teaching and learning in the “West,” or North America etc., may not occur in the same way as among hunter-gatherers, in that we learn through books

and schools, but the same processes are at work and these processes reinforce a particular mode of engagement with the world. For example, although astronauts are the only individuals who have seen the world as a globe, Ingold suggests that this (global) perspective is mirrored in the classroom model globe: “in both cases the world appears as an object of contemplation, detached from the domain of lived experience” (1993b: 32). It is through books, school, technology, medical practices, and even our language (see Abram, 1996 with regards to the latter), that structures the environmental context in which we learn how to do things and relate to the world and others (Ingold, 1997c: 11).

The second implication of viewing knowledge as MTK has been discussed earlier, and involves the notions of differences in thought or different kinds of knowledge (*e.g.*, Young, 1981, 1982). The separation of different kinds of knowledge or thought maintains the divisions between patient, biomedical practitioner and other types of medical practitioners. As I argued, the distinction of disease, illness, and also disorder (Hahn, 1984), in medical anthropology suggests that patients and practitioners have different kinds of knowledge or cognition. I am not denying biomedical knowledge, *nor* any other medical system’s knowledge regarding ill-health. This is an issue of perception or perspective and not of “knowledge.” As Good contends, “[M]eaning and knowledge are always in reference to a world constituted in human experience, formulated and apprehended through symbolic forms and distinctive interpretive practices” (1994: 177). But contrary to my argument, and reflecting the global perspective, Good suggests, “The empirical world always transcends our knowledge; and technology, symbolic formations, and social practices open up worlds to our experience — and to knowledge” (1994: 177). Granted biomedical technology has opened up some worlds to experience and

¹⁵ I am not implying that this is what Ingold is necessarily doing though.

knowledge, it has also closed off some worlds, such as the world or “nature” (Ingold, 1993b, 1998b; Mitcham, 1996) or, as Garro argued earlier, other, non-biomedical etiologies and treatments (2000: 321; *cf.* Good, 1994):

We discover, here, a direct connection between the notion of the world as a solid globe and the idea, commonly encountered even in anthropological literature, of the environment as a *substrate* for the external imposition of arbitrary cultural form. The world becomes a *tabula rasa* for the inscription of human history. [Ingold, 1993b: 37]

If we continue to consider medical systems and practices through the lens of knowledge (as MTK) our ability to understand them is hindered for two interconnected reasons. First, MTK separates medical systems and practices from their context within the world, which leads to the second: the incomparability of biomedicine and other medical systems, thereby maintaining the biomedicine-ethnomedicine dichotomy.

The solution to the hindrance, as I have argued, lies in the resituation of medical systems and practices back into their contexts. I use the word “contexts” not in the sense of wider sociocultural contexts; rather I use the word as connoting a person’s engagement, which involves perception, with the world. The resituation of medical systems and practices in the world appears to apply theoretically more to biomedicine as authors such as Anyinam (1995) and Voeks and Sercombe (2000) seem to imply. But resituating medical systems and practices does not completely overcome the problem, because we are still comparing medical knowledge and practices. We are still left with the question asked at the close of the previous chapter: “How are biomedical practices related to the *sbəltədaq* ceremony?”

If, on the other hand, we look at various medical systems and practices as differences in perception/perspective, we no longer compare the “technologically”

laden biomedicine with the “religious” ethnomedicines. Rather, we compare them as different ways of approaching or perceiving ill-health and the world (as in Ingold, 1993b). The difference between the biomedical perspective and any other medical system’s perspective becomes “not one of hierarchical degree, in scale or comprehensiveness, but one of kind” (Ingold, 1993b: 40). Considering medical systems and practices as alternate ways of perceiving, we resituate them back into their contexts — but not in the sense of being grounded in their contexts, for this separates them from a dynamic engagement with the world and experience. Instead, we resituate them in their hybridic relationships, as I attempted to show in my discussion of the *sbəłtədaq* ceremony in the preceding chapter. Biomedicine and ethnomedicines are no longer different or dichotomized, rather we can drop both heavily problematized terms and consider the various medical systems found throughout the world as each providing a mode of perceiving ill-health and the world.

Finally, by grounding biomedicine in experience, the fallen unity of biomedicine (Mol and Berg, 1998: 4-5) is no longer a problem, as differences/variability in biomedicine arises because no two people will have the identical experiences.¹⁶ Thus, biomedicine as a cosmopolitan notion does not exist, because no two biomedical practitioners have experienced it identically, nor have they the same general experiences (beyond the biomedical arena). How does one explain that there is a hospital nearby that is filled with practitioners who have at least similar approaches so that we could call them all biomedical practitioners? Through guided rediscovery, as evidenced by Good and Good (1993).

¹⁶ See also Good’s similar point that some of the problems arising in the biomedical physician-patient interactions are due to these differences in experience or life worlds (1994: 90).

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APPENDIX A:

Lushootseed Glossary

<u>Lushootseed</u>	<u>English</u>
<i>ʔəswəli</i>	Zalmai “Zeke” Zahir
<i>absčəčqsali</i>	Mosquito place
<i>–abs̓</i>	people of
<i>–dup</i>	distribution or expanse
<i>dxʷʔastaqaxʷ</i>	beaver dam
<i>dxʷʔatəbəd</i>	wide lake location
<i>dxʷdəwʔabs̓</i>	Duwamish
<i>q̓ilbid</i>	canoe (of any type); vehicle of any kind
<i>q̓iq̓adəd</i>	jumping place
<i>sbət̓ədəq</i>	spirit world journey
<i>səliʔ</i>	soul, life
<i>səxʷləx̌ab</i>	prairie location
<i>sgʷədilič</i>	a kind of spirit power
<i>siʔat̓</i>	Seattle
<i>sləx̌il</i>	Dawn
<i>spuyaləpabs̓</i>	Puyallup
<i>sqəlalitut</i>	guardian spirit
<i>sqəlalitutdup</i>	ceremonial object location
<i>sqʷiʔqʷaliʔ</i>	hay or grass
<i>sqʷəl</i>	berry thicket location
<i>ssqʷaliʔabs̓</i>	Nisqually
<i>stəqəxʷ</i>	beaver
<i>swatixʷtəd</i>	land, country, place, region or world
<i>swaw̓tixʷtəd</i>	Little Earths
<i>syuʔwən</i>	spirit power; Winter Spirit Dance, Spirit Dance, Winter Dance
<i>taqʷšəblu</i>	Vi Hilbert
<i>təstəd</i>	a ceremonial staff or pole
<i>yapəntukʷ</i>	Lois Hilbert

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